Wellness for You NOW Chiropractic **Dr. Joseph Manza, DC, CACCP**

We are honored and blessed that you have chosen our office to serve your family.
Please know that we will care for your children with the greatest respect and tenderness.

Pre-school Child History 3-5 years

Child's Name_____Birthdate_____ Sex: M F

Address_____City_____Zip_____

Parents' Names_____

Parent's Phone_____Work#_____

Parent's Employer_____Position/Duties_____

Siblings and ages_____
_____

Whom may we thank for referring you to our office? _____

Please take a few moments to read the following information as it will aid you as you complete this form.

The human body is designed to be healthy. The primary system in the body that coordinates health is the nervous system. The healthy function of every cell, every system and every organ is dependent upon the integrity of the nervous system. The bones of the skull and vertebrae of the spine house and protect the central nervous system.

From the birth process until the present, events have occurred in your child's life that may have caused interference and damage to this delicate system. Physical, emotional and chemical stresses common to our contemporary lifestyles can result in less than ideal spinal health. This interference is called the Vertebral Subluxation Complex (VSC).

We are becoming more aware of how current technological lifestyles and practices expose our children's nervous systems to continuous stresses. These result in Vertebral Subluxations.

Current scientific research shows the direct relationship between the function of the nervous system and the immune system. The integrity of the nervous system is therefore imperative to a healthy immune system in your growing child.

Today, your child has the opportunity to have a spinal analysis by a Doctor of Chiropractic, the only health care provider qualified to locate, analyze and correct the Vertebral Subluxation Complex. Correction of the Subluxation with the Chiropractic Adjustment is the beginning of greater health and well-being for your child.

Completing this form in its entirety will help reveal the causes of Vertebral Subluxation that interfere with the optimal function of your child's nervous system and therefore impair your child's inborn health and well-being.

Thank you for choosing Wellness for You NOW Chiropractic! We know there is no more precious gift than the health and happiness of your child.

REASON FOR TODAY'S VISIT: _____

Does your child complain of pain or discomfort? Yes No If yes, when did this occur? _____

Was the onset: ____ Sudden ____ Gradual Is the problem: ____ Constant ____ Intermittent

Has your child ever had this problem before? Yes No If Yes:_____

Has your child previously been treated for this problem? Yes No By whom? _____

Has your child previously had chiropractic care? Yes No By whom? _____

NUTRITION

Do you have any concerns about your child's diet? Yes No If Yes:_____

Does your child have any food allergies? Yes No If Yes:_____

Does your child have any persistent or intermittent skin rashes? Yes No If Yes:_____

Does your child take vitamin supplements? Yes No If Yes:_____

Does your child eliminate stools each day? Yes No If No, How often:_____

Does your child have any digestive disturbances? Yes No If Yes:_____

For how long was your child breast-fed? _____

What does your child usually eat for breakfast? _____

What does your child usually eat for lunch? _____ _____

What does your child usually eat for dinner? _____

What does your child usually eat for snacks? _____

What type, and how often does your child eat fast food? _____

How much cow's milk does your child drink/day? _____

TRAUMA

Place of birth:	___ Home	___ Birthing Center	___ Hospital
Provider:	___ Midwife	___ OB-Gyn.	Other_____
Type of Birth:	___ Vaginal	___ C-section	___ emergency ___ scheduled
Was the birth:	___ Doctor assisted	___ Forceps	
	___ Vacuum Extraction	___ Twisting/Pulling	Other_____

Was your child breech? Yes No

Was there any trauma to your newborn? Yes No If yes, please describe _____
_____

Has your child had any recent falls or trauma? Yes No
If yes, please describe: _____

Has your child ever fallen from a bicycle, skateboard, scooter, rollerblades or similar? Yes No
If Yes_____

Has your child ever fallen down stairs or fallen from any height? Yes No If Yes_____

What sporting activities does your child engage in?

___ Soccer	___ Football	___ Gymnastics	___ Hockey	___ Lacrosse	___ Swimming/Diving
___ Dance	___ Wrestling	___ Baseball/Softball	___ Martial Arts	___ Basketball	___ Field Hockey

Other_____

Has your child ever been in a motor vehicle collision or near miss? Yes No If Yes:_____

Has your child had any other trauma or injuries? Yes No If Yes:_____

Has your child ever had a bone fracture/dislocation Yes No If Yes:_____

HEALTH HISTORY

In order to better understand your child's level of health, please check any of the following body signals you have noticed your child currently or previously displaying.

___ Colic	___ Headaches	___ Digestive problems	___ Irregular Sleeping Patterns
___ Ear Infections	___ Seizures	___ Bed Wetting	___ Learning Disorders
___ Allergies	___ Tantrums	___ Chronic colds	___ Emotional Disorders
___ Asthma	___ Night Terrors	___ Chronic Infections	___ ADD/ADHD or Autism Spectrum

Other: _____

Does your child ever complain of back or neck pain? Yes No If Yes:_____

Does your child ever complain of pains in the arms and legs? Yes No If Yes:_____

Does your child ever complain of headaches? Yes No If Yes:_____

Has your child had asthma? Yes No If Yes:_____

Is your child allergic to anything? Yes No If Yes:_____

Are there any smokers in the child's home? Yes No

Has your child had any earaches? Yes No At what age did the first earache occur? _____

How frequently does your child have earaches?_____

How many courses of antibiotics has your child been exposed to? _____

Has your child had any other illnesses? Yes No If Yes:_____

Is your child presently receiving any medications? Yes No If Yes:_____

Has your child ever been to a hospital or emergency room for evaluation or treatment? Yes No If Yes:_____

Has your child recently been vaccinated? Yes No

Do you have any other concerns about your child's health? Yes No If Yes:_____

QUALITY OF LIFE AND CURRENT HEALTH STATUS

How do you grade your child's physical health? Excellent Good Fair Poor

How do you grade your child's emotional/mental health? Excellent Good Fair Poor

How do you grade your child's overall "quality of life"? Excellent Good Fair Poor

Do you believe your child is expressing their full health potential? Yes No If no, why? _____

How can we/chiropractic help your child achieve their optimum health? _____

_____

FINANCIAL POLICIES:

I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I agree that I am responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand that if I suspend or terminate my care, any fees for professional services rendered me will become immediately due and payable.

AUTHORIZATION TO EXAMINE/PROVIDE CARE TO A MINOR:

I hereby Authorize Dr. Joseph Manza to perform a chiropractic evaluation, and provide chiropractic care to my child.

Parent/Guardian: _____ _____ _____

Print name Signature Date

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