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.

TODDLER HISTORY 12 months to 24 months

Child's Name______________________________________Birthdate________________ Sex: M F

Address____City____________________Zip_________

Parents' Names____

Parent's Phone____________________________________Work#______________________________

Parent's Employer__________________________________Position/Duies_____________________

Siblings and ages____

Pediatrician____Office #______________________

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 ____________________________________

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

Is your child still being breast fed? Yes No If no, how long were they breast-fed? ______________

Is your child formula fed? Yes No If yes, which formula or milk source? ______________

Is your child eating solid food? Yes No If yes, what foods? ______________________
____

Does your child have any feeding difficulties? Yes No ____________________________________

Does your child have any digestive disturbances? Yes No ____________________________________

Does your child have any food allergies? Yes No ____________________________________

Does your child have any skin rashes? Yes No ____________________________________

Is your child receiving any vitamin supplements? Yes No ____________________________________

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 If Yes:______________________________

Was there any trauma to your newborn? Yes No If Yes:______________________________
If yes, please describe medical procedures and tests: ______________________________________

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

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

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:______________________________

Does your child ever bang his/her head
repeatedly against a wall, bed or other object? Yes No If Yes:______________________________

GROWTH AND DEVELOPMENT

Can your child sit unsupported? Yes No If yes, at what age did they start? ________________

Is your child crawling yet? Yes No If yes, at what age did they start? ________________

Is your child walking yet? Yes No If yes, at what age did they start? ________________

Does your child often trip and fall? Yes No If Yes:______________________________

Do you have any other concerns about your child's growth and development? Yes No If Yes:________________

HEALTH HISTORY

Has your child had colic? Yes No If Yes:____

Has your child had any upper respiratory infections? Yes No
How often? :____

Has your child had asthma? Yes No

Does your child ever complain of arm/leg pain? Yes No If Yes:____

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

Has your child had any infections? Yes No If yes, at what age did they begin? ____________________

How frequently does your child have infections? _________ How many courses of antibiotics? ________

Has your child had any other illnesses? Yes No If yes, please describe: ______________________________
____

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
Were there any adverse reactions to the vaccinations?____

Do you have any other concerns about your child's health? Yes No ____
____

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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