

Your Child's Wellness History

Date: _____
Name: _____ Birth date: _____ Age: _____ Male / Female
Address: _____ City: _____ State: _____ Zip: _____
Home # () _____ Mother's work # () _____ Father's work # () _____
Mother's Name _____ Father's Name _____
Birth Weight _____ Current Weight _____ Birth Length _____ Current Length/Height _____
Siblings' Names & Ages: _____

Referred to our Office by: _____
Purpose for contacting us: _____
Other Chiropractors seen for this concern: _____
Date of last visit: _____ Reason for visit: _____
Other Doctors seen for this concern: _____
Date of last visit: _____ Reason for visit: _____
Name of Pediatrician: _____
Date of last visit: _____ Reason for visit: _____
Other health concerns? _____

Check any of the following conditions that may apply to your child:

- | | | | | |
|---|---|---------------------------------------|--|---|
| <input type="checkbox"/> Ear infections | <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Seizures | <input type="checkbox"/> Chronic Colds | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Asthma/Allergies | <input type="checkbox"/> Digestive Problems | <input type="checkbox"/> ADHD | <input type="checkbox"/> Recurring Fever | <input type="checkbox"/> Growing/Back Pains |
| <input type="checkbox"/> Colic | <input type="checkbox"/> Bed Wetting | <input type="checkbox"/> Car Accident | <input type="checkbox"/> Temper Tantrums | <input type="checkbox"/> Other _____ |

Number of Rounds of Antibiotics your child has taken:

In the last 6 months: _____ Total during life span: _____

Number of Rounds of Other Prescription Medications your Child has taken:

In the last 6 months: _____ Total during life span: _____

Has your child received vaccinations? No Yes If yes please list vaccines & dates: _____

Prenatal History:

Name of Obstetrician/Midwife: _____ Location of birth: Home Birthing Center Hospital
Complications during pregnancy? No Yes If yes please list _____
Ultrasound exams during pregnancy? No Yes If yes, how many _____
Birth interventions? induction Artificial rupture of membranes Forceps Vacuum extraction
 C-section, ER or Planned?
Complications during Labor/Delivery? No Yes If yes, please list: _____
Genetic Disorders/Anomalies? No Yes If yes, please list: _____
Medications during pregnancy? No Yes If yes, please list: _____
Cigarette/Alcohol use during pregnancy? No Yes If yes, please list: _____



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Feeding History:

Breast fed? No Yes How long? _____ Formula fed? No Yes How long? _____

Introduced to solid food at what age? _____ Cow's milk at what age? _____

Food/juice allergies/intolerances No Yes if yes, please list: _____

Habits

Amount & Frequency

_____ Dairy _____

_____ NutraSweet (aspartame) _____

_____ Soda pop (reg/diet) _____

_____ Snoring _____

_____ Clenching/Grinding teeth _____

_____ Carry heavy bag/backpack Right side Left side

Sleep posture: Right side Left side Back Stomach

Developmental History:

During the following milestones of development, your child's spine is most vulnerable to stress and should routinely be checked by a Doctor of Chiropractic for prevention aid early detection of vertebral subluxation and spinal nerve interference.

At what age was your child able to:

_____ Respond to sound _____ Cross crawl _____ Respond to visual stimuli (3+ mos.)

_____ Stand alone _____ Hold head up (5-6 mos.) _____ Walk alone _____ Sit up (9-10 mos.)

According to the National Safety Council, approximately 50% of children fall head first from a high place during their first year of life (i.e. from a bed, changing table, down the stairs, et) Is this the case with your child? No Yes

Is/has your child been involved in any high impact or contact sports (i.e. soccer, football, gymnastics, basketball, baseball, cheerleading, martial arts, etc.)? No Yes If yes, please list: _____

Has your child ever been involved in a car accident? No Yes If yes, please list: _____

Has your child ever been seen on an emergency basis? No Yes If yes, please list: _____

Prior surgeries? No Yes If yes, please list: _____

Date of first menstrual cycle (if applicable)? _____

Childhood Diseases:

Chicken Pox No Yes Age _____

Mumps No Yes Age _____

Rubeola (Measles) No Yes Age _____

Whooping Cough No Yes Age _____

Rubella (German measles) No Yes Age _____

Other _____ No Yes Age _____

Health Attitudes:

_____ Treatment only: I only consult a doctor when I or my child have/has an ache or pain and discontinue as soon as it has cleared up.

_____ Prevention: In addition to symptomatic treatment, I consult specialists occasionally to prevent problems from recurring.

_____ Maintaining Health: I'm conscious about my health, diet, exercise, etc. and actively pursue these in order that I and my family feel better perform better and It maximizes each of our potential.

_____ Family health: I take an active part in assisting, informing and maintaining health with my family. I'm concerned with long term effects of good health and wellness.

Authorization For Care of Minor

I hereby authorize this office and its Doctors to administer care as they deem necessary to my son/daughter.

Parent/Legal guardian signature

Witnessed by

Date

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