



The Body Well Chiropractic

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Welcome!

Your first visit to our practice is an opportunity for us to learn all about you and your family. It is a time for you to share with us where you are now in your health and life, as well as what you would like to move toward. *And away we go!*

Personal Information - Pediatric

Name _____ Birth Date ____/____/____ Today's Date ____/____/____

Phone (H) _____ (W) _____ Ext. _____ (Cell) _____

Address _____
Number & Street City State Zip

Parent's Email Address _____

Mother's Name _____ Father's Name _____

Are parents ☐ Single ☐ Married/Partnered ☐ Widowed ☐ Divorced

of Kids in family ____ How many at home? ____ Names & ages _____

Has your child been to a chiropractor before? ☐ Yes ☐ No Approximate date of last visit ____/____/____

Dr.'s Name/City/State _____ Good results? ☐ Yes ☐ No

Is your child under care of any other doctor? Yes/No If Yes, the condition being treated for _____

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

Your child's favorite hobbies or interests _____

Labor and Delivery History

Did you and/or your child experience any of the following during the labor/delivery

☐ Hospital birth	☐ Home birth	☐ Birthing home	☐ The labor was induced
☐ Long and/or difficult labor	☐ The delivery was rapid	☐ Placenta previa	☐ Forceps or suction cup used
☐ Elective c-section	☐ Emergency C-section	☐ Fetal distress	☐ Cord around the neck
☐ The child was premature (2+ weeks)	☐ The child was a "blue baby"	☐ Breech birth	☐ Other (explain)

Please list reasons for any interventions/complications during labor and delivery _____

Rank mother's general stress level (0-10) during pregnancy _____

Did mother smoke during pregnancy? Yes/No

Any illness of mother during pregnancy? Yes/No If yes, please explain _____

List any drugs/medications (including over-the-counter) taken during pregnancy _____

Let's Find Out Why You're Here...

Reason for seeking chiropractic care _____

Any other specific concerns? _____

If seeking chiropractic for a specific concern, has your child been treated for this concern before? Yes/No

Please explain _____

When did this concern begin? _____

List all current medications and conditions being treated _____

List any vitamins/herbs/homeopathics/other your child is taking _____

Has child received any vaccinations? Yes/No If yes, list any reactions _____

Has your child received any antibiotics? If yes, how many times and list reason _____

List any past surgeries or hospitalizations and dates _____

List any past accidents and dates _____

List any injuries _____

Has your child ever been under chiropractic maintenance care? _____

Date of your child's last adjustment (if applicable)_____

Do you know what a subluxation is? If yes, please describe _____

Is/was your child breastfed? Yes/No If yes, how long? _____

Any difficulty with breastfeeding? Explain. _____

Is/was your child formula fed? Yes/No If yes, how long? _____

Any difficulty with bonding? Yes/No If yes, please explain _____

Any behavioral problems? Yes/No If yes, please explain _____

Does your child have regular bowel/bladder movements? Yes/No

Quality of Life Inventory

If your child has experienced any of the following, please indicate by writing

C (Current), **P** (Past) or **CP** (Current and Past).

___ Fatigue	___ Sinus problems	___ Digestion problems	___ Chronic ear infections/earaches
___ Diabetes	___ Frequent colds	___ Nervousness	___ Serious fall(s) or repetitive falls
___ Fainting	___ Head injury	___ Sleeping problems	___ Illnesses with a high fever
___ Asthma	___ Serious illness	___ Difficulty focusing	___ Trouble with bladder control
___ Anxiety	___ Meningitis	___ Seizures/Convulsions	___ Joint or muscle problems
___ Cold Sweats	___ Heart problems	___ Urinary problems	___ Nausea
___ Weakness	___ Loss of balance	___ Mood swings	___ Neck or back problems
___ Dizziness	___ Skin Conditions	___ Low energy/tired	___ Ringing in ears
___ Headaches	___ Ulcers	___ Allergies to foods	Other _____
___ Migraines	___ Cancer	___ Environmental allergies	

Let's Make Sure We're On the Same Page...

When an individual or family seeks and is accepted into a program of **function-based** chiropractic care, it is essential for all parties to be working toward the same objectives. We have only one goal, and it is important that everyone understands both our objective and the methods we will use to move consistently toward that objective.

Your care in our center is not a substitute or alternative for, nor is it a preventative form of *medicine*.

Medically-based care specializes in the *diagnosis* and *treatment* of specific symptoms, illness and disease.

Our function-based chiropractic care specializes solely in helping people of all ages ensure that their spines and nerve systems are functioning as optimally as possible. This in turn allows their bodies to work the best they possibly can.

So, while the natural result of optimal function *is* increased **health, wellness** and an **overall improved quality of life**, we will not treat or attempt to cure any specific physical, mental or emotional ailment, nor will we give advice about specific medical conditions or treatments.

If you are seeking care for the removal of a *specific* medical symptom or condition, we suggest you seek additional help from a symptom, illness, and disease orientated professional if you feel that our function-based approach will not be sufficient in progressively raising you to the levels of health, wellness and quality of life you desire for yourself and your family.

I, _____, have read and understand the above statement and I hereby give permission for Dr. Erin Torzewski to continue with my child's and/or my initial consultation and assessment. I also agree to return at a later date to allow Dr. Erin to report her findings and recommendations to me. By agreeing to this, I am in no way obligated to follow the advice given to me in the report of findings.

I also understand that The Body Well Chiropractic does not participate with third party insurance carriers. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. I will be responsible for any costs of collection, attorney's fee or court costs required to collect my bill.

Signed _____ Date ____/____/____

We sincerely thank you for choosing our center and for taking the time to honestly reflect upon and share your current level of health and well being, as well as your goals.

We look forward to helping you maximize your experience and expression of health and life!