



Your Wellness History – Pediatric Profile

Name: _____ DOB: _____ Age: _____ Male Female
 Name of Parent/Guardian: _____ Parent/Guardian's work place: _____
 Address: _____ City: _____ Prov: _____ PC: _____
 Telephone: Home _____ Work: _____ Cell: _____
 Email address: _____
 Have you seen a Chiropractor before? Yes No M.D. _____
 Who did you see? _____ What techniques were used? _____
 Have you ever seen a wellness chiropractor? Yes No
 How did you hear about our office? _____

Your Health Profile

Why This Form is Important?

As a Creating Wellness Centre, we focus on your ability to be healthy. Our goals are to first address the issues that brought you to this office and second, to offer you the opportunity of improved health, wellness and quality of life in the future. On a daily basis we all experience physical, biochemical and psychological/emotional stresses that can accumulate and result in serious loss of health potential. Most times the effects are gradual and may not even be felt until they become serious. Answering the following questions will give us a profile of the specific stresses past and present that you face and allow us to better assess the challenges to your health potential.

Please check all symptoms you have ever had, even if they do not seem related to your current problem.

<input type="checkbox"/> Headaches	<input type="checkbox"/> Childhood vaccinations	<input type="checkbox"/> Loss of smell	<input type="checkbox"/> Frequent colds
<input type="checkbox"/> Pins and needles in arms	<input type="checkbox"/> Childhood illnesses	<input type="checkbox"/> Loss of taste	<input type="checkbox"/> Sinus infection
<input type="checkbox"/> Pins and needles in legs	<input type="checkbox"/> Depression/Mood Swings	<input type="checkbox"/> Speech problem	<input type="checkbox"/> Allergies
<input type="checkbox"/> Numbness in fingers	<input type="checkbox"/> Nervousness / Anxiety	<input type="checkbox"/> Head injuries	<input type="checkbox"/> Enlarged glands
<input type="checkbox"/> Numbness in toes	<input type="checkbox"/> Irritability	<input type="checkbox"/> Back pain	<input type="checkbox"/> Thyroid problems
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Scoliosis	<input type="checkbox"/> Neck pain	<input type="checkbox"/> Cardiovascular problems
<input type="checkbox"/> Loss of balance	<input type="checkbox"/> Hip Pain	<input type="checkbox"/> Stiff neck	<input type="checkbox"/> Poor circulation
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Fever	<input type="checkbox"/> Joint pain	<input type="checkbox"/> Cold hands / feet
<input type="checkbox"/> Sleeping problems	<input type="checkbox"/> Fainting	<input type="checkbox"/> Swollen joints	<input type="checkbox"/> Respiratory problems
<input type="checkbox"/> Tension	<input type="checkbox"/> Urinary problems	<input type="checkbox"/> Skin rashes	<input type="checkbox"/> Head Tilt (wryneck/ torticollis)
<input type="checkbox"/> Ear / Eye pain	<input type="checkbox"/> Eyes bothered by light	<input type="checkbox"/> Bruise easily	<input type="checkbox"/> Enuresis (Bed Wetting)
<input type="checkbox"/> Buzzing / Ringing in ears	<input type="checkbox"/> Blurred / Double vision	<input type="checkbox"/> Asthma	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Ear Infection	<input type="checkbox"/> Stomach upset	<input type="checkbox"/> Constipation / Diarrhea	<input type="checkbox"/> Menstrual Challenges
<input type="checkbox"/> Broken Bones	<input type="checkbox"/> Concussion		

Please list any vitamins or medications taken: _____

Surgeries/Hospitalizations: _____

Motor vehicle accidents: _____

Mother's Health during Pregnancy (smoking, drinking, illness, medications): _____

Duration of Gestation: _____ Type of Birth (Vaginal, cesarean, induced, forceps): _____

Birth Injuries/Trauma: _____

Was the child breast or bottle fed? _____ How Long? _____

Does the child have any food allergies? _____

Family Health Profile

Is there a family history of:

Mother: Arthritis Heart Disease Cancer Diabetes Other: _____

Father: Arthritis Heart Disease Cancer Diabetes Other: _____

Chief Complaint

What brings you into our office today? _____

Location:

Onset:

Duration:

Radiation:

Frequency:

Intensity:

Character:

Aggravating factors:

Relieving factors:

Associated Symptoms:

Does this interfere with your: School work Sleep Sports Other

Have you seen other doctors for this condition? Chiropractor MD Other

Name: _____ Date: _____

Were you pleased with the results? Yes No

Your Goals

➤ On a scale of 1 to 10 (1 = none, 10 = extreme), describe your emotional/psychological/lifestyle stress levels:

Scale = _____ School stress: _____

Scale = _____ Personal stress: _____

➤ On a scale of 1 to 10 (1 = poor, 10 = excellent), describe your habits and condition as it relates to:

Eating _____ Exercise _____ Sleep _____ Energy Levels _____ General Health _____ Wellness lifestyle _____

I consent to a professional and complete chiropractic examination, and to any diagnostic scans and radiographic examination that the doctor deems necessary. I understand that all fees for services rendered are due at the time of service and cannot be deferred to a later date.

Signature parent/guardian: _____ Date: _____

Witness: _____ Date: _____

