PURE LIGHT
CHIROPRACTIC

Child/Infant Survey

Child Information

Child's Name _____ Date: _____

Date of Birth _____ Age _____ *Sex*: □ F □ M Height: ___ Weight: _____

Siblings names and ages: _____

_____

_____

Guardian Information

Parent/Guardian Names: _____

Address: _____

_____

Phone: Cell _____ Work _____ Home _____

Email: _____

Who referred you to Pure Light? _____

Do you have a specific concern that brings you in? □ No, I'm interested in having my child's nervous system assessed to achieve optimal health and functioning □ Yes: _____

_____

_____

_____

Health concerns/diagnoses: _____

Current medications (including over-the-counter): _____

_____

Number of **courses of Antibiotics** child has taken in the past year: □ 1-3 □ 4-7 □ 8-10

Total in Lifetime: _____ Reason(s) for antibiotics: _____

GENERAL HEALTH HISTORY

Allergies

☐ seasonal _____ ☐ medication(s) _____

☐ food(s): _____

Any **pets** at home: ☐ No ☐ Yes **Type** of Pet(s):_____

Any **smokers** in the home: ☐ No ☐ Yes Do they smoke inside? ☐ No ☐ Yes

Vaccinations: ☐ Yes ☐ No Any reaction(s): _____

_____

Physical Traumas

Has your child ever fallen from a high place?.....☐ No ☐ Yes _____

Has your child ever been involved in a motor vehicle accident?.....☐ No ☐ Yes _____

Has your child been seen on an emergency basis?.....☐ No ☐ Yes _____

Has your child broken any bones?.....☐ No ☐ Yes _____

Has your child been hospitalized?.....☐ No ☐ Yes _____

Previous surgeries?.....☐ No ☐ Yes _____

Time using a tablet, computer or video games?.....☐ Never ☐ Rarely ☐ Daily ☐ Several hrs/day

Does your child watch television?.....☐ Never ☐ Rarely ☐ Daily ☐ Several hrs/day

Does your child exercise?.....☐ No ☐ Daily ☐ Weekly ☐ Seasonally

Does your child play contact sports?.....☐ No ☐ Daily ☐ Weekly ☐ Seasonally

Does your sleep on their.....☐ Back ☐ Belly ☐ sides (both, right, left)

Does your child carry a backpack? .....☐ No ☐ Yes _____

Does it weigh less than 15% of their body weight? .....☐ No ☐ Yes _____

Do they wear it on 2 shoulders?.....☐ No ☐ Yes _____

Does your child show excessive or uneven shoe wearing out? .....☐ No ☐ Yes _____

Does your child wear custom orthotics?.....☐ No ☐ Yes _____

What signals has your child's body been communicating? Current (c) Previous (p)

C P	C P	C P
☐ ☐ Asthma	☐ ☐ Food Sensitivities	☐ ☐ Slow reflexes
☐ ☐ Respiratory Tract Infections	☐ ☐ Digestive Issues	☐ ☐ Asymmetrical gait
☐ ☐ Sinus Problems	☐ ☐ Diarrhea or Constipation	☐ ☐ Bed-wetting
☐ ☐ Ear Infections	☐ ☐ Slow weight gain	☐ ☐ Tip-toe walking
☐ ☐ Strep Throat/Tonsillitis	☐ ☐ Headaches	☐ ☐ Missed Milestones
☐ ☐ Frequent Colds	☐ ☐ Neck Pain	☐ ☐ Seizures/tremors
☐ ☐ Recurrent Fevers	☐ ☐ Head Tilt	☐ ☐ ADD/ADHD
☐ ☐ Skin Conditions	☐ ☐ Trouble feeding	☐ ☐ Autism
☐ ☐ Sleep Problems	☐ ☐ Back Pain	☐ ☐ Behavioral issues
☐ ☐ Colic/frequent crying	☐ ☐ Growing Pains	

Early Childhood History

(FILL OUT IF CHILD IS UNDER 5 YEARS OLD)

BIRTH HISTORY: □ Hospital □ Birthing Center □ Home **Was Birth**: □ Vaginal □ C-Section

Gestation: ___weeks _____ days / Birth Weight _____lbs ___ oz / Length _____inches

Assisted birth: □ **Yes** □ **No** I**f yes:** □ forceps □ vacuum extraction □ C-section □ induced-labor
Was your child at any time in the following constraining position? □ Breech □ Transverse
□ Posterior/Sunny Side Up

Complications at birth: □ Yes □ No If **yes**, explain: _____

Evidence of birth trauma: □ bruises □ odd-shaped head □ stuck in birth canal
□ fast birth □ excessively long birth □ respiratory depression □ cord around neck

□ other _____

POST NATAL:

Does your child frequently **arch** his/her head and neck **backwards**? □ Yes □ No
Does your child **cry** often? □ Yes □ No If yes, how many hours per day? _____
Is your child currently **breast-fed**? □ Yes, exclusively □ No □ formula supplemented
If no, how long was your child breast-fed? _____Weeks/months **Type** of formula: _____
Any difficulties with **lactation?** □ Yes □ No **One-sided preference?** □ Right □ Left
Any difficulties with **latching?** □ Yes □ No If yes, describe _____
Does your child frequently **spit up** after feeding? □ Yes □ No
Was there introduction of **cow's milk?** □ Yes □ No If **yes**, at what age_____
Does your child pass a lot of intestinal gas? □ Yes □ No
Has your child shown any sensitivities to foods? □ Yes □ No _____
How many times a **week** does your child **eat the following**:

Gluten: _____ Dairy: _____ Sugar: _____ Processed Foods: _____

Please write any questions you have below

_____

_____

_____

_____

Terms of Acceptance

When a person seeks chiropractic health care and we accept a person for such care, it is essential for both to be working towards the same objective. Chiropractic has only one goal. It is important that each person understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is through specific adjustments of the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebrae in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal evaluation, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **OUR PRACTICE OBJECTIVE** is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, _____ have read and fully understand the above statements.
(Print name)

All questions regarding the Chiropractor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis.

_____ _____
Signature **Date**

Consent to evaluate and adjust a minor

I, _____ being the parent or legal guardian of _____

Have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

_____ _____
Signature of Parent or Guardian **Date**

HIPPA ACKNOWLEDGMENT

Please initial the following:

_____I acknowledge that Laine Morales, D.C. has provided me with a written copy of the Notice of Privacy Practices and that I have been afforded the opportunity to read the Notice of Privacy and ask questions.