The Health Connection
CHIROPRACTIC • ACUPUNCTURE • MASSAGE

New Patient Registration Pediatrics

(Ages birth to 5 years)

CAUSE

The human body is designed to be healthy. The primary system in the body which 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 which may have caused interference and damage to this delicate system. Physical, emotional and chemical stresses common to our contemporary lifestyles can result in misalignment and damage to the spinal column. This interference is called the Vertebral Subluxation Complex. This form will help reveal the causes of Vertebral Subluxation which interfere with the optimal function of your child's nervous system and therefore impair your child's inborn health and well-being.

CORRECTION

Today, we are becoming more aware, how current technological lifestyles and practices expose our children's nervous systems to continuous stresses. These result in Vertebral Subluxations.

Current scientific research is showing the direct relationship between the function of the nervous system and the immune system function. 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.

Pediatric Health History and Vertebral Subluxation Assessment

First Name: **Middle Initial:** **Last Name:**

Date of Birth: / / Age: _____ **Gender:** [ ] Male [ ] Female **Height:** _____ **Weight:** _____

Address: **City/State/Zip:**

Home Phone: **Work Phone:** **Cell Phone:**

Email:

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Primary reason for consulting this office?

_____

Any additional concerns?

_____

_____

Has your child ever been checked by a Doctor of Chiropractic? Yes/ No Whom?

_____

- Were x-rays taken?_____. Who is your regular pediatrician? _____

Experts around the world agree: the birth process as we know it can cause spinal Subluxation complexes as well as extensive neurological trauma and/or damage.

Did you have ultrasound during this pregnancy? _____

Frequency_____

- Place of birth: Home/ Birthing Center/ Hospital
- Provider: Midwife/ OB-Gyn/
  Other_____
- Type of Birth: Vaginal / C-section. Was anesthesia
  used?_____Type:_____ Complications? _____
  Full term? _____ Birth Ht./Wt._____
- Was labor induced? _____ If yes, why?_____
- What position did you deliver in: Squatting/ On Back
- Birth Trauma: Doctor assisted/ Twisting, Pulling/ Vacuum Extraction/ Forceps
- Newborn trauma (medical procedures and tests)_____
  Apgar scores at birth? _____Spontaneous respiration? _____
  Any complications or nursery stay?_____

Did you breast-feed your child? _____yes _____ no. How long? _____

Was your decision supported by your health care provider? ___yes ___no

If child is currently on solid foods, how would you describe his/her appetite?_____

Allergies (drugs, chemicals, foods, etc.) _____

How would you rate your child's diet?_____

Does your child consume artificial sweeteners? _____Fluoridated water?_____

How often does your child have a bowel movement?_____

Has your child reached all of the expected milestones for their age category?_____

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601 South Pine Street #201 ♦ Tacoma, WA 98405 ♦ Office: (253) 396-1000 ♦ Fax: (253) 396-1012

Are there any concerns?_____

According to the National Safety Council approx. 50% of infants have fallen onto their heads during their first years of life. Another study reveals 1/4 million children are injured in playgrounds annually.

Can you recall any such jolts, falls or traumas to your child?_____

Please Describe:_____

Any fractures or dislocations? _____

Which sports does your child play? Soccer/ Football /Gymnastics/ Karate/ Hockey/ Lacrosse/ Basketball/ Dance/ Wrestling/ Baseball/ Other_____

Other than the 5 hours per day spent sitting in the classroom, does your child spend additional prolonged time sitting? __yes___no. Is it in front of a computer or TV?_____

Circle any of the following conditions your child has suffered from:

Colic, Irregular Sleeping Patterns, Night Terrors, Seizures, Tantrums, Ear Infections, Allergies, Asthma, Headaches, Poor Digestion, Repeated Infections or Colds, Bed Wetting, Learning Disorders, Emotional Disorders, ADD or ADHD, Other_____

How would you rate your child's immune system? _____Specific illnesses?_____

Is your child currently on any medications? (Please list) _____

Has your child been treated with antibiotics? _____How many times?_____

Any surgeries?_____

The child's immune system, like all other developing systems of the body is both intricate and delicate. It strives for a state of homeostasis and balance in the body. Long term, adverse effects from interfering with this process of artificial immunization is just being uncovered. Were you adequately informed of the risks of vaccinating your child? _____Were you informed of their adverse reactions? ____yes____ no

Did your child experience any behavioral, emotional or physical changes within 3 months after any shots?____

Describe: _____Was it reported by you or your doctor? ____yes____ no

How often has your child been treated with drugs and/or vaccinations? _____

If you chose to vaccinate, did you follow the typical vaccine schedule or did you determine a vaccination schedule that is more suited to your child?_____

Are you aware of the fact that vaccines are not mandatory for school age children?_____

AUTHORIZATION FOR CARE OF A MINOR

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I hereby authorize **Dr. Eyford** to administer care as deemed necessary to my son/daughter.

Parent/Guardian_____

Date_____

Signature_____

Date_____

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