

Wellness for You NOW Chiropractic

Dr. Joseph Manza, DC, CACCP

We are honored and blessed that you have chosen our office to serve your family.
Please know that we will care for your children with the greatest respect and tenderness.

CHILDHOOD 6-12 years

Child's Name _____ Birthdate _____ Sex: M F

Address _____ City _____ Zip _____

Parents' Names _____

Parent's Phone _____ Work# _____

Parent's email _____

Parent's Employer _____ Position/Duties _____

Siblings and ages _____

Pediatrican _____

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

REASON FOR TODAY'S VISIT

Does your child complain of pain or discomfort? Yes No If yes, when did this occur? _____

Was the onset: ___ Sudden ___ Gradual Is the problem: ___ Constant ___ Intermittent

Has your child ever had this problem before? Yes No _____

Has your child previously been treated for this problem? Yes No By whom? _____

CHIROPRACTIC

Has your child had their spine and nervous system checked by a chiropractor? Yes No

If yes, who was the chiropractor, when were they last seen, and what was the original reason for being checked? _____

Were x-rays taken? Yes No If yes, when were they taken: _____

NUTRITION

How would you rate your child's diet? Excellent Good Fair Poor

How many servings of fruits and vegetables per day? _____

Does your child consume: ___ Sodas ___ Processed foods ___ High sugar foods (cereal/donuts)
___ Sweeteners ___ Fast food ___ Simple Carbs (bagels, white bread)

Other/explain: _____

TRAUMA

Place of birth: ___ Home ___ Birthing Center ___ Hospital.

Provider: ___ Midwife ___ OB-Gyn. Other _____

Type of Birth: ___ Vaginal ___ C-section

Was the birth: ___ Doctor assisted ___ Forceps
___ Vacuum Extraction ___ Twisting/Pulling Other _____

Has your child had any recent falls or trauma? Yes No

Describe the trauma and the date it occurred: _____

Has your child ever fallen from a bicycle, skateboard, scooter, rollerblades or similar? Yes No

Has your child ever fallen down stairs or fallen from any height? Yes No If Yes: _____

Has your child ever been in a motor vehicle collision or near miss? Yes No If Yes: _____

Has your child had any other trauma or injuries? Yes No If Yes: _____

Has your child ever had a bone fracture/dislocation Yes No If Yes: _____

Has your child had any surgeries? Yes No If Yes: _____

What sporting activities does your child engage in?
 Soccer Football Gymnastics Hockey Lacrosse Swimming/Diving
 Dance Wrestling Baseball/Softball Martial Arts Basketball Field Hockey

Other: _____

Other than sitting in the classroom, does your child spend additional prolonged time sitting? Yes No
 How much: _____ Is it in front of a computer or TV? _____

How would you rate your child's posture? Excellent Good Fair Poor

Please explain what you observe about their posture (slouch, forward head etc.): _____

Health History:

Has your child suffered from any of the following?

Colic Headaches Digestive problems Irregular Sleeping Patterns
 Ear Infections Seizures Bed Wetting Learning Disorders
 Allergies Tantrums Chronic colds Emotional Disorders
 Asthma Night Terrors Chronic Infections ADD/ADHD or Autism Spectrum

Other: _____

Does your child ever complain of back or neck pain? Yes No If Yes: _____

Does your child ever complain arm/leg pain? Yes No If Yes: _____

Are there any smokers in the child's home? Yes No

Has your child had any earaches? Yes No At what age did the first earache occur? _____

How frequently does your child have earaches? _____

How many courses of antibiotics has your child been exposed to? _____

Is your child presently receiving any medications? Yes No If Yes: _____

Has your child ever been to a hospital or ER? Yes No If Yes: _____

Do you have any other concerns about your child's health? Yes No If Yes: _____

Quality of life and current health status:

How do you grade your child's physical health? Excellent Good Fair Poor

How do you grade your child's emotional/mental health? Excellent Good Fair Poor

How do you grade your child's overall "quality of life"? Excellent Good Fair Poor

Do you believe your child is expressing their full health potential? Yes No If no, why? _____

How can we/chiropractic help your child achieve their optimum health? _____

Thank you for choosing Wellness for You NOW Chiropractic!
We know there is no more precious gift than the health and happiness of your child.