

Little Person Life Story

Name _____ Age _____ Birthday _____

Address _____ City _____ State _____ Zip _____

Name(s) and age(s) of siblings _____

Parent(s)/Guardian (s) Name(s) _____

Parent(s)/Guardian(s) occupation(s) _____

Parent (s)/Guardian (s) Phone (Home) _____ (Work/Cell) _____

Who may we thank for referring you and your child to Serving Life Chiropractic? _____

Is your child currently benefiting from chiropractic care? Yes No

When was their last visit? _____

Name of your family chiropractor _____

What would you like your child to receive from care in this office? _____

Have you consulted any other health care practitioners for this reason? Yes No

If Yes, Who: _____

Many of the health challenges that people will face originate from stressors experienced during developmental years (including gestation and birth). These stressors (traumas) may be emotional, mental, physical, or chemical. This health record is designed to help us understand the stressors your child might have already experienced, and to maximize your child's health and wellness.

The Pregnancy Process

During the pregnancy process, did the mom:

Take medications? Type _____

Smoke or consume alcohol or drugs? _____

Experience any illness? Type _____

Undergo a lot of stress? _____

Receive ultrasounds or other radiation? _____

The Birthing Process

Birthplace: Home Hospital Birthing Center

Type of Birth: Vaginal C-Section

Cephalic (head first) Breech (feet first) Occiput Posterior (facing forward)

Procedures: Forceps Vacuum Extraction

Birth Assistants: M.D. Midwife Doula

Did the person assisting the delivery twist or pull the baby during the delivery? Yes No

How long did labor & delivery last? _____ hours

What was the mother's position during labor? Back Side Sitting Standing Other _____

Did the mother have an episiotomy? Yes No

Was labor chemically induced? Yes No

What was the child's gestational age at birth? _____

Was your child breast-fed soon after the birth? Yes No

Were any drugs administered during the labor process (IV or epidural)? Yes No

Was your child subjected to any of the following?

Silver Nitrate eye drops Incubation (how long) _____ Vitamin K injection

Hepatitis injection Separation from mother (how long) _____

Vaccinations

Have you chosen to vaccinate your child? Yes No

If yes, check all vaccinations received: DPT MMR Polio Chicken Pox

Hepatitis Flu

Other _____

Describe any reactions to the vaccine(s): _____

Growth and Development

At what age did your child:

Follow an object _____ Respond to sound _____

Hold up head _____ Vocalize _____

Sit unassisted _____ Teethe _____

Crawl _____ Walk _____

Has your child's body communicated any of the following?

vision problems

pink eye

constipation

headaches

ear problems

asthma

sleeping difficulty

tubes in the ears

colic

irritability

attention problems

allergies _____

skin problems

frequent colds

bedwetting

breathing problems

digestive problems

hyperactivity

other _____

Is your child accident-prone? _____

Average number of hours your child watches television, plays on the computer,
or plays electronic games each week, if any _____

Do you feel that your child's social and emotional development is normal for their age?

(Please explain) _____

Any night terrors, sleep walking, difficulty sleeping? _____

Has your child:

Been hospitalized/surgery? No Yes: _____

Had a severe fall? No Yes: _____

Been in a car accident? No Yes: _____

Any child traumas resulting in bruises, fractures, or stitches? _____

Any sports participation and age began? (list sports and number of hours/week) _____

Approximate hours of playtime each week _____

Is a school backpack used? (Heavy or Light) _____

Has your child ever taken antibiotics (OTC or prescription)? Yes No

If yes, how often & why: _____

Has your child ever taken or currently taking any other medications (OTC or prescription)?

Yes No

If yes, explain: _____

Does your child consume:

- caffeine soda sugar artificial sweetener fast food processed foods
 tap water/unfiltered water/plastic bottled water

What changes in your child's health or behavior would you like to see? _____

Is now a good time to commit to cultivating these changes? _____

Who is on your child's health care team (massage, nutrition, acupuncture, etc ?) _____

Chiropractors Notes:

(please leave blank)



