BREATH
OF LIFE
wellness center

Welcome!

I want to personally congratulate you on your first step toward better health. It is my privilege to provide southwest Missouri with alternatives in natural health care. I was blessed to have parents that utilized alternative natural health care. There was no worry of side effects or addictions. By choosing alternative natural health care you are choosing to empower you, the individual, with comfort, confidence and knowledge to take control of your health and wellness. Throughout my education, I have learned that there are many ways to care for the body and I choose preventative care. We never know what future problems we avoid by taking preventative action. We are proud to care for your family from womb to tomb!

Thank you for your trust,

Dr. Nicole McCauley
Breath of Life Wellness Center

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TERMS OF ACCEPTANCE

Please Read Carefully

We encourage and support a shared decision making process regarding your health needs. As part of that process you have the right to be informed about the condition of your health and the recommended care and treatment to be provided to you so that you can make the decision whether or not to undergo care with full knowledge of the known risks. This information is intended to make you better informed in order that you can knowledgeably give or withhold your consent.

Wellness Care enables each individual to maximize his or her health. Health can only be maximized when the major cause of interference is removed and balance is obtained.

Health: A state of optimal physical, mental, social, and spiritual well-being, not merely the absence of disease or infirmity. Health will be maximized if all obstructions to it are removed.

Chiropractic: Chiropractic is based on the science that concerns itself with the relationship between structures (primarily the spine) and function (primarily the nervous system) and how this relationship can affect the restoration and preservation of health.

Subluxation: An imbalance of health due to nervous system interference in the spinal column, cranium and/or contiguous structures of the body. The result is a lessening of the body's inborn "innate" ability to express life at maximum potential.

Adjustment: An adjustment is the special application of forces to facilitate the body's correction of subluxation. Our method of correction is by specific adjustments of the spine, contiguous structures and soft tissues. Adjustments are made by chiropractors in order to correct or reduce spinal and extremity joint subluxations. Vertebral subluxation is a disturbance to the nervous system and is a condition where one or more vertebra in the spine is misaligned and/or does not move properly causing interference and/or irritation to the nervous system. The primary goal of chiropractic care is the removal and/or reduction of nerve interference caused by vertebral subluxation.

Regardless of what a disease is called, we do not offer to treat it, nor do we offer advice regarding treatment prescribed by others. We believe any named condition is merely a physical manifestation and not necessarily indicative of the underlying cause. Our only objective is to remove interference to the expression of your body's infinite wisdom, thus returning your body to balance. We do not offer to diagnose or treat any disease or condition. However, if during the course of examination, we encounter unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we give you the option to seek the service of a health care provider who specializes in symptom-based care.

A chiropractic examination will be performed which may include spinal and physical examination, orthopedic and neurological testing, palpation, specialized instrumentation, radiological examination (x-rays), computerized electrodermal testing and laboratory testing.

The chiropractic adjustment is the application of a precise movement and/or force into the spine in order to reduce or correct vertebral subluxation(s). There are a number of different methods or techniques by which the chiropractic adjustment is delivered but are typically delivered by hand. Some may require the use of an instrument or other specialized equipment. In addition, physiotherapy or rehabilitative procedures may be included in the management protocol. Among other things, chiropractic care may reduce pain, increase mobility and improve quality of life.

In addition to the benefits of chiropractic care and treatment, one should also be aware of the existence of some risks and limitations of this care. The risks are seldom high enough to contraindicate care and all health care procedures have some risk associated with them.

Risks associated with some chiropractic care may include soreness, musculoskeletal sprain/strain, and fracture. Risks associated with physiotherapy may include the preceding as well as allergic reaction and muscle and/or joint pain. In addition there are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic care and the occurrence of stroke; rather, recent studies indicate that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence, there is a stroke already in process. However, you are being informed of this reported association because a stroke may cause serious neurological impairment.

The Vital (CEDSA) System provides a completely non-invasive method for gaining valuable information about your body's vital functions. The primary objective of the procedure is to disclose patterns of stress and to provide feedback to help in recommending a program to restore each system and meridian (energy pattern) to balance.

I understand that the Computerized Electrodermal Stress Analysis Survey does not provide a medical diagnosis, and that my testing technician may recommend further medical testing. If you suspect that you need further medical intervention, you should consult your physician.

I give my permission for the testing technician to evaluate me on the CSA System. I understand that by doing so THE TESTING TECHNICIAN IS NOT BECOMING MY PRIMARY CARE PHYSICIAN.
I understand that the testing technician will give me information about myself based on the evaluation and the testing technician will make recommendations to improve my health based on what is found.

Any decision to follow through with the program will be my own decision, and I will not hold the testing technician or Breath of Life responsible.

I have read the above paragraphs. I have been informed of the nature and purpose of chiropractic care, the possible consequences of care, and the risks of care, including the risk that the care may not accomplish the desired objective. Reasonable alternative treatments have been explained, including the risks, consequences and probable effectiveness of each. I have been advised of the possible consequences if no care is received. I acknowledge that no guarantees have been made to me concerning the results of the care. I understand the information provided. All questions I have about this information have been answered to my satisfaction. Having this knowledge, I knowingly authorize Dr. Nicole McCauley to proceed with Chiropractic Care.

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Dated This Day _____ of _____ , 20_____

_____ _____

(Practice Member Signature) (Date)

_____ _____

(Doctor Signature) (Date)

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Parental Consent for Minor Practice Member

Patient Name _____

Patient Age _____ DOB _____

I am the parent, guardian, or personal representative of _____
(Please print name of minor / child)

and there are no court orders now in effect that prohibit me from signing this consent. I do hereby request and authorize the doctor and practice staff to perform necessary services for the child named above, which are deemed advisable by the doctor.

_____ _____
(Signature of Practice Member, Parent, Guardian or Personal Representative) (Date)

_____ _____
(Print Name of Practice Member, Parent, Guardian or Personal Representative) (Date)

I request that my child be able to maintain their chiropractic appointments without the presence of a parent/guardian when necessary. (This applies to children 14 years of age or older.)

_____ _____
(Signature of Practice Member, Parent, Guardian or Personal Representative) (Date)

_____ _____
(Witness Signature) (Date)

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NOTICE OF PRIVACY PRACTICES

Please Read Carefully

In the course of my care as a practice member at Breath of Life Wellness Center (BOL) my personal information may be used or disclosed in the following ways:

- My personal health information, including my clinical records, may be disclosed to another health care provider or hospital, should I choose concurrent care.
- My health care and billing records may be disclosed to another party, such as an insurance carrier or my employer, with my expressed written consent.
- my name, address, phone number, email address, and health care records may be used to contact me regarding appointment reminders, missed appointment notification, billing/collection efforts, birthday cards, holiday related cards, newsletters, information about treatment alternatives or other related information that may be of interest to me.
- I give permission to leave a phone message on my answering machine or voice mail.
- I give permission to send a thank you letter including my name to the person referring me to this office.
- I give permission to use my name on a welcome board, referral board, and birthday board.
- I give permission to use my photograph on their patient picture bulletin board and other marketing materials such as their brochure, website and ads in print media.
- I give permission to use any testimonials written by me for marketing purposes such as, sharing with other patients or potential patients, in their brochure, or on their website or in ads in print media.
- By signing this form, I am giving BOL permission to use and disclose my PHI in accordance with the directives listed above.
- I have the right to inspect or copy, within boundaries, the protected health information to be used/ disclosed. A reasonable fee for copying will apply. A copy of the signed authorization will be provided to me.
- I have the right to obtain a copy of the information that will use for these purposes. I also have the right to refuse authorization for BOL to contact me regarding these matters. My decision to refuse authorization will not affect the care I receive in any way.
- Under Federal Law, BOL is permitted or required to use or disclose your health information without your consent or authorization in the following circumstances:
- If BOL is providing health care services to you based on the orders of another health care provider.
- If BOL provides health care services to you in an emergency.
- If BOL required by law to provide care to you and we are unable to obtain your consent after attempting to do so.
- If there are substantial barriers to communicating with me, but BOL believes, in their professional judgment that I intend for BOL to provide care.
- If BOL is ordered to do so by the courts or another appropriate agency.

Any use or disclosure of my protected health information, other than as outlined above, will only be made with my express written authorization. BOL will normally provide information about my health to me in person at the time of my appointment.

BOL may also mail information to me regarding my health care or about the status of my account. If I would like to receive this information at an address other than my home or in a different format, I will advise BOL in writing of my preferences.

I have the right to inspect and copy my health information for seven years from the date the record was created, or as long as the information remains in the BOL office files. In addition, I have the right to request an amendment to my health information. Requests to inspect, copy, or amend my health related information should be provided to BOL in writing.

State and Federal Laws requires BOL to maintain the privacy of my patient file and the protected health information therein. BOL is also required to provide me with this notice of their privacy practices with respect to my health information.

Furthermore, BOL is required by law to abide by the terms of this notice while it is in effect. BOL reserves the right to alter or amend the terms of this privacy notice. If changes are made to BOL's privacy practices, I will be notified in writing as soon as possible following the changes. Any change in BOL's privacy practices will apply to all my health information on file.

Information used or disclosed based on this privacy notice may be subject to re-disclosure by the person to whom this office provides the information and may no longer be protected by the Federal Privacy Rule.

Under Federal Law BOL is required to ask for my permission to leave a message regarding confirming my appointment times and meetings and informing of products. The purpose of this use is to make a more pleasant, personable, efficient, and productive Wellness Center as well as further enhancing my access to quality health care.

If I choose not to authorize this information use, my decision will NOT affect my care in this office or my relationship with BOL's staff.

My signature indicates my authorization of this activity. This authorization will remain in effect for the duration of my care at BOL plus seven years or until revoked by me.

I have been provided with a copy of the Notice of Privacy Practices for Protected Health Information. The Notice of Privacy practices describes the types of uses and disclosures of my Protected Health information (PHI) that will occur in my treatment, payment of my bills or in the performance of health care operations of this BOL. A copy of this notice is attached and I have been encouraged to read it and request a copy if I would like one.

This Notice of Privacy Practices also describes my rights and duties of the Chiropractor with respect to my protected health information. I hereby give permission to BOL to use and/or disclose my PHI in accordance with the following:

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I have read and understand this patient Authorization to release Health Information and acknowledge receipt of The Notice of Privacy Practices for Protected Health Information. My signature below represents agreement with these practices.

_____ _____

(Practice Member Signature) (Date)

_____

(Print Name)

_____ _____

(SSN) (DOB)

Parental Consent for Minor Practice Member

_____ _____

(Signature of Personal Representative) (Date)

_____

(Print Name of Parent or Personal Representative Name)

_____

(Print Name of Parent or Personal Representative Name)

_____

(Relationship to Minor Practice Member)

I may revoke this authorization at any time in writing. I will allow 2 weeks for this change to be completed.

Right to Revoke Authorization

I have the right to revoke this AUTHORIZATION, in writing, at any time. However, my written request to revoke this AUTHORIZATION is not effective to the extent that BOL has provided services or taken action in reliance on my authorization.

I may revoke this AUTHORIZATION by mailing or hand delivering a written notice to the Privacy Official of BOL. The written notice must contain the following information:

1. My printed name, SSN, address, and DOB
2. A clear statement of my intent to revoke this AUTHORIZATION
3. Date of my request
4. My signature

The revocation is not effective until it is received by the Privacy Official.

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This AUTHORIZATION is requested by BOL for its own use/disclosure of PHI. (Minimum necessary standards apply.)

I have the right to refuse to sign this AUTHORIZATION. If I refuse this AUTHORIZATION, BOL will not refuse to provide care; however, I will be responsible for:

1. Payment in full at the time services are provided to me.
2. Scheduling my own appointments since BOL will be unable to contact me.
3. All contact with BOL regarding my care.
4. Additionally, any collection activity as permitted by law is not waived by refusal to sign the AUTHORIZATION.

This notice is effective as of **September 1, 2014**. This notice and any alterations or amendments made hereto will expire seven years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice.

_____ _____

(Signature) (Date)

_____

(Print Name)

_____

(Alternate phone number where a message may be left)

RESPONSIBLE PARTY

Name of Person Responsible for Account _____

Address _____

_____

Home Phone _____

Name of Employer _____

Work Phone _____

Relationship to Practice Member _____

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CERTIFICATION AND ASSIGNMENT

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health. I understand that I am financially responsible for all charges.

_____ _____

(Signature of Parent, Guardian or Personal Representative) (Date)

_____ _____

(Print Name of Parent, Guardian or Personal Representative) (Relationship to Minor)

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Pediatric Health History

Child's Name _____

Address _____

Home Phone _____

Sex ☐ M ☐ F

Date of Birth _____

Referred By _____

Mother's Name _____

Father's Name _____

Home Phone _____

Cell Phone _____

Work Phone _____

Parents' Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed

List Name and Ages of Other Children In Family

_____

_____

Predominant language used at home? _____

Pregnancy

Check all that apply, and describe if checked.

☐ Were there any complications to the pregnancy? _____

☐ Was mom on any medications, prescriptions or over the counter? _____

_____

☐ Did mom or dad smoke during the pregnancy? Who? _____

☐ Was the baby ever in Breech position? _____

☐ How many ultrasounds were performed? _____

☐ How does mom rate her overall health during pregnancy? _____

During the pregnancy, did you have any of the following?

☐ Falls

☐ Motor vehicle accidents

☐ Near-miss car accidents

☐ High blood pressure

☐ Diabetes

☐ Anemia

☐ Morning sickness

☐ Indigestion

☐ Seizures

☐ Swollen ankles

☐ Thyroid problems

☐ Heart problems

☐ Back pain

☐ Abnormal bleeding

☐ Were you hospitalized

☐ Did you have any other illnesses _____

During your pregnancy, did you use any of the following?

☐ Tobacco

☐ Alcohol

☐ Non-prescribed drugs

☐ Prescription medications

Medications and Reasons _____

_____

Labor and Delivery

How much assistance chemically, physically and emotionally did mom have during delivery?

_____

Where was the baby born?

☐ Home

☐ Hospital

☐ Birthing Center

☐ Other _____

☐ Was there a Midwife or a Doula present? _____

Type of delivery

☐ Vaginal

☐ C-section

☐ Planned

☐ Emergency

Were any devices used?

☐ Forceps

☐ Vacuum

How long was the labor? _____

How long was the delivery? _____

☐ Was oxytocin/pitocin used? _____

☐ Was an epidural administered? _____

☐ Was there fetal distress? _____

☐ Was there meconium staining? _____

☐ Was an episiotomy performed? _____

What position did mom labor in? _____

What position did mom deliver in? _____

☐ Head/Face/Breech presentation? _____

Baby's Condition Immediately After Birth

APGAR Scores:

At 1 minute _____/10

At 5 minutes _____/10

Baby's Crying

☐ Baby cried immediately after birth

☐ Cried Strongly

☐ Weak Cry

☐ Did not cry for _____ minutes

Baby's Color

☐ Pink all over

☐ Blue face

☐ Blue hands and feet

Baby's Activity

☐ Arms and legs actively moving

☐ Floppy baby

☐ Was intensive care required? Days in Neonatal Intensive Care _____

☐ Medicine given at birth _____

☐ Vaccines administered _____

Birth weight _____lbs/kg

Birth length _____in/cm

Baby went home on day _____

Present Health Challenges

On a scale of 0-100, how healthy is your child and why? _____

Where would you like them to be? _____

How long will it take to get there? _____

What is your child's present health challenge? _____

What do you believe caused your child's present health challenge? _____

How persistent does it present? _____

☐ Is this dysfunction getting progressively worse? _____

If yes, why do you think so? _____

How long has your child had this problem? _____

What makes it better or worse? _____

What have you attempted to improve this condition? _____

Are we the 1st practitioner to evaluate the child's present condition? _____

Discuss previous treatments utilized. _____

_____

Why do you think they were successful or unsuccessful and why? _____

_____

☐ Has your child seen a chiropractor before? _____

Chiropractor's name? _____

What are your perceptions of what a chiropractor does? _____

_____

Why do you think we can help? _____

What plan does your pediatrician have for your child to develop optimum health? _____

_____

☐ Do you feel your child's present diet, environment and/or age is related to his/her present health challenge?

If yes, please explain. _____

How do you feel your child's present health challenge affects his/her overall health and ability to experience an optimal quality of life? _____

How does it affect your whole family? _____

_____

How would you describe your child's overall health prior to his/her present health challenge?

_____

☐ Any history of Congenital Abnormalities and/or Chronic Disease?

☐ Is your child experiencing any acute levels of stress at this moment? _____

Are there any problems you can foresee occurring with your child being examined by the doctor?

_____

☐ Has your child been vaccinated? _____

☐ Does your child ever complain of back or neck pain? _____

☐ Does your child complain of pains in the legs or arms? _____

☐ Does your child complain of headaches? _____

☐ Is your child allergic to anything? _____

☐ Are there any smokers in the child's home? _____

☐ Has your child had earaches? _____

At what age did the first earache occur? _____

How frequently does your child have earaches? _____

Which ear? ☐ Right ☐ Left ☐ Both

☐ Is your child taking any prescribed medication? _____

Please list any other illnesses that have been a concern for your child: _____

_____

Please list any surgeries your child has had: _____

Please describe any other concerns you have about your child's health:

☐ Does your child often trip and fall? _____

☐ Do you have any other concerns about your child's growth and development? _____

_____

☐ Has your child had colic? _____

☐ Has your child had any upper respiratory infections? _____

How often? _____

☐ Has your child had asthma? _____

☐ Has your child ever been cared for in the emergency room? _____

☐ Has your child ever been hospitalized? _____

☐ Has your child ever been diagnosed with neurological disease? _____

☐ Has your child ever had any surgeries? _____

☐ Are you at present taking any medications? _____

☐ Do you have any other health problems? _____

☐ Has your child ever fallen down stairs or fallen from a significant height? _____

☐ Has your child ever been in a motor vehicle collision or near-miss? _____

☐ Has your child ever had a bone fracture or joint dislocation? _____

☐ Does your child ever bang his/her head repeatedly against a wall, bed, or other object? _____

☐ Has your child had any recent falls or trauma? _____

Description & Date? _____

☐ Other than today's presenting complaint, please list any and all concerns regarding your child's overall health that you wish to discuss. _____

_____

Newborn History

☐ Was there any prolonged use of medicines or an inhaler? _____

If yes, which? _____

☐ Did the infant suffer any trauma such as serious falls or car accidents? _____

How many hours does your baby sleep between feeds? _____

During day _____ At night _____

☐ Does baby go to sleep easily? _____

☐ Does baby have a preferred sleeping position? _____

☐ Does baby cry if you change this sleeping position? _____

☐ Does your baby have any feeding difficulties? _____

☐ Is baby breast feeding? _____

If no, for how long was baby breast fed? ____ weeks ____ months

☐ Does baby have one sided feeding preference? ☐ Left ☐ Right

☐ Is your baby formula fed? _____

Which formula/ milk source? _____

☐ Does baby frequently spit up after feeding? _____

☐ Does baby cry a lot? _____

How many hours each day? _____

☐ Does baby pass a lot of intestinal gas? _____

☐ Does baby have a preferred head position? _____

☐ Does baby frequently arch his/her head and neck backwards? _____

☐ Does baby cry or become irritable during a diaper change? _____

☐ Has baby ever had a fever? _____

☐ Has baby had any falls? _____

☐ Has baby been in a car accident or near-miss? _____

☐ Has baby had any other trauma? _____

☐ Has there been any trauma, signs of alteration of posture, delay/guarded and/or abnormal movements?

_____

☐ Have all initial milestones been met? _____

☐ Was there an immediate bond formed through breastfeeding and caressing at birth? _____

☐ How much separation occurred in the first few days of life? _____

☐ What was the mother's state of mind during the first 12 weeks of life? _____

_____

☐ What role did father, grandparents, friends play in the first month of life? _____

_____

☐ Was the child placed in the care of a third party before 12 weeks, 6 months of life? _____

☐ Do you have any other concerns you wish to discuss? _____

_____

Infant History (2 months – 2 years)

☐ Can your child sit unsupported? _____

☐ At what age did your child start to sit up? _____ months.

☐ Is your child crawling? _____

At what age did your child start crawling? _____ months.

☐ Is your child walking? _____

At what age did your child start walking? _____ months.

Pre-School Child History (3 years – 5 years)

Trauma

☐ Does your child have a problem with bedwetting? _____

☐ Has your child ever fallen from a bicycle, skateboard, scooter, or similar? _____

Nutrition

What does your child usually eat for breakfast? _____

What does your child usually eat for lunch? _____

What does your child usually eat for dinner? _____

What snacks does your child eat? _____

What is your child's favorite food? _____

How much water does your child drink each day? _____

How many sodas does your child drink each day? _____

How much cow's milk does your child drink each day? _____

How often does your child eat fast food? _____

☐ Does your child have any food allergies? _____

☐ Does your child get skin rashes? _____

☐ Does your child take vitamin supplements? _____

☐ Does your child eliminate stools each day? _____

☐ Does your child consume artificial sweeteners such as those found in sugarless, fat free products? _____

If yes, what type of artificial sweeteners does your child use? _____

At what age did you introduce solid foods into your child's diet? _____

What type(s)? _____

☐ Has your child exhibited any tolerance and/or allergy to any specific food? _____

If yes, please list all foods _____

☐ Did your child have any chronic overexposure to the same foods? _____

☐ Was your child introduced to some foods too early? _____

☐ Are there any recent dietary changes? _____

☐ Do you have concerns about your child's diet? _____

About Your Lifestyle

What grade is your child in at school? _____

How does your child carry their school book bag? _____

How heavy is your child's book bag? _____

What sports does your child play? _____

What hobbies does your child have? _____

How many hours each day does your child watch TV? _____

How many hours each day does your child spend at the computer? _____

How often does your child play video games? _____

On average, how many hours of sleep does your child get each night? _____

☐ Does your child feel stressed out? _____

☐ Does your child have trouble reading the board in class? _____

☐ Does your child have blurred vision? _____

☐ Does your child wear glasses or contacts? _____

☐ Does your child get headaches when they read? _____

Emotional Stress

☐ Has your child suffered emotional trauma? _____

☐ Does your child live in a blended or divorced family? _____

☐ Has your child experienced a loss (i.e. loved one, pet, etc)? _____

How did your child respond to new surroundings? _____

How do they respond to the word "No"? _____

☐ Have they exhibited outward signs of frustration, anger or inappropriate laughter? _____

_____

☐ Has your child had any history of abuse? _____

Please list the (3) most significant stressful events in your child's life from the most recent to the most distant. _____

_____

_____

☐ Are any of these situations continuing to impact his/her life? If yes, please explain clearly.

_____

_____

Environmental Stress

☐ Has your child been exposed to pesticides/herbicides? _____

☐ Has your child been exposed to petroleum-based products? _____

☐ Has your child been exposed to plastics? _____

☐ Has your child been exposed to household/body cleaning chemicals? _____

☐ Has your child been exposed to new furnishing/flooring? _____

Physical Stress

☐ Has your child experienced past physical trauma? _____

☐ What is your child's level of activity in daily life? _____

☐ Do they experience any repetitive stress exposures? _____

☐ Is/was your child involved in any contact sports? _____

Please check any of the following sports activities that your child is engaged in.

☐ Football	☐ Lacrosse	☐ Soccer	☐ Track/Field
☐ Bowling	☐ Tennis	☐ Hockey	☐ Volleyball
☐ Baseball/Softball	☐ Skateboarding	☐ Snowboarding	☐ Skiing
☐ Gymnastics/Trampoline	☐ BMX/Motocross	☐ Swimming	☐ Golfing

☐ Has your child ever been injured while playing sports?

If yes, what type of injury(s) occurred? _____

☐ Does your child experience any pain symptoms not as a result of an injury? _____

☐ Does your child exhibit abnormal posture while seated, standing, or sleeping? _____

☐ Any difficulty with walking, running, bending, lifting, swinging, or climbing? _____

Medical Intervention

☐ Did your child have any childhood illnesses? _____

_____

Please list any and all other concerns regarding your child's health and whether or not you feel they are related to your child's primary reason for being seen in our office today.

☐ Allergies _____

☐ Frequent colds/congestion _____

☐ Upper respiratory infections _____

☐ Asthma _____

☐ Ear infections _____

☐ Infected/sore throat _____

☐ Tonsillitis _____

☐ Laryngitis _____

☐ Colic _____

☐ Reflux/spitting up _____

☐ U-tract infections _____

☐ Poor appetite _____

☐ Poor digestion/ (constipation/diarrhea) _____

☐ Thrush mouth/chronic diaper rash _____

☐ Eczema/psoriasis/other skin rashes _____

☐ ADD/ADHD _____

☐ Irregular sleep patterns _____

☐ Night terrors _____

☐ Bed wetting _____

☐ Headache _____

☐ Anxiety _____

☐ Mood swings _____

☐ Bruising _____

☐ Has there been any prolonged use of medications? _____

☐ Does your child have a history of chronic use of broad spectrum antibiotics? _____

☐ Please list any and all prescription medications that your child is presently using and has used on more than one occasion. _____

_____

☐ Has your child chronically used over-the-counter fever reducers/decongestants/cough/cold remedies?

_____

☐ Has your child taken any of these products that contain acetaminophen or ibuprofen? _____

☐ If yes, for what reason and for how long? _____

_____

☐ Has your child had any surgery? _____

☐ Has your child ever been hospitalized? _____

☐ If yes, why and when? (Please list in chronological order) _____

☐ Please list any and all injuries experienced by your child, how they occurred and what action was taken to correct them. _____

_____

Allergies

☐ Has your child been tested for allergies? _____

☐ If yes, how were the tests performed? _____

☐ What were the results? _____

☐ If your child does have an allergy, how does it present itself? (Skin rash, hives, ENT/respiratory, digestive symptoms) _____

☐ Has your child received treatment for any type allergy? _____

☐ If yes, what type of treatment? _____

☐ Please give us any other health information you feel would be helpful: _____

_____

_____

6 years and Older

- ☐ Any difficulties during growth? _____
- ☐ Any injuries during growth? _____
- ☐ Any changes in overall health since growth spurt? _____
- ☐ Any problems with moving particular joints since growth spurt? _____
- ☐ Does your child exhibit signs of puberty? _____
- ☐ Has menses occurred? _____