# Application for Care

**Welcome**_____________________________________________________________________________**to our place of hope!**
GUARDIAN LAST NAME FIRST MIDDLE

Today ___________________________our team is honored that you entrusted us with the care of _______________________________
DATE CHILD'S LEGAL NAME

(A most precious gift of life) and we look forward to partnering with you and your family along this journey towards optimum health.
**To whom may we thank for referring you to our place of HOPE?**____________________________________________________

I understand that referrals have built this practice and I Do or Do Not (circle one) give permission to use our names in giving thanks for my future referrals.

_____________________________ (Boy ☐Girl ☐) was born into this amazing world on: ___________________________________
CHILD'S FIRST NAME (or NICKNAME) MONTH DATE YEAR

making them____________young. They were assigned the SS#:______________________________________ but to us your child is
AGE

not a number but a **member of our family** that serves to make this a healthier and happier community.

Our mailing address is:_________________________________________________________________________
ADRESS CITY/STATE ZIP

Our email address is:___________________________________________________________________________

I can be reached in the case of need at the following: Cell#_________________________________

Home#_________________________________

Work#_________________________________

I give permission to send me emails & text message reminders: **Y** or **N**

My employer is _______________________________________ and I have worked there ______________years.
How Long

I am a/an _______________________by trade and I am currently ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed
Occupation

The following is a list of my family members:

______________________________________________
Spouse Name DOB Age

______________________________________________
Children DOB Age

______________________________________________
Children DOB Age

______________________________________________
Children DOB Age

______________________________________________
Children DOB Age

## Childs Current Health:

What health challenge brings your child to our place of Hope?

___________________________________________________________________________________________________

_______________________________________________________________________________________

_______________________________________________________________________________________

_______________________________________________________________________________________

*Please turn over*

When did you first notice this challenge?

______________________________________________________________________________

To what do you relate the cause?

______________________________________________________________________________

Is this dysfunction getting progressively worse or staying the same? ___Yes ___No ___Same

Why do you think so?

______________________________________________________________________________

Has your child ever experienced this before? ___Yes ___No

If yes, please explain: ______________________________________________________

What measures have you taken to date to help this present health challenge?_______________________

______________________________________________________________________

Have you sought the advice of another healthcare practitioner? If so, what treatments were rendered and did you notice any change (good or bad).

______________________________________________________________________________

______________________________________________________________________________

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.

______________________________________________________________________________

______________________________________________________________________________

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.

______________________________________________________________________________

__________________________________________________________________________

☐My child has no complaints; he/she is here to express full potential!

"Every Effect has a Cause and every Cause has Effects" BJ Palmer

***This section is all about the uniqueness of your child***

***Toxic Stressors:*** **(Chemical)**

During pregnancy was the baby exposed to any types of smoke, **Y** or **N**? If yes, please explain: ____________________

______________________________________________________________________________

Did the mother drink alcohol while pregnant, **Y** or **N**? If yes, give more details (during what trimester, what type was consumed, how much and how often).

______________________________________________________________________________

______________________________________________________________________________

Did the mother experience any Illness during pregnancy **Y** or **N**? If yes, please explain: ______________________

______________________________________________________________________________

Did the mother take any supplements (prenatal, vitamin D etc…) during pregnancy, **Y** or **N**? If yes, what was supplemented?

______________________________________________________________________________

Was the mother exposed to any drugs/medication or vaccines during either the pregnancy or the delivery process (including over the counter medications).______________________________________________________________
______________________________________________________________

Was ultrasound utilized during pregnancy, **Y** or **N**? If yes, during what months?
______________________________________________________________

Has your child received any vaccinations, **Y** or **N?** If yes, which one(s) at what age(s) and how did your child respond to the vaccine?
______________________________________________________________
______________________________________________________________

Name of Pediatrician or primary care provider: ________________________

Was your child breast-fed? If yes, how for how long? ____________ Formula introduced at age: ___________

What type of formula was used? ______________________________________________

What age was commercial baby food introduced?__________

Does your child have any food or drink intolerances that your know about, **Y** or **N?** If yes, what type of intolerance?
______________________________________________________________
______________________________________________________________

Has your child been diagnosed with a food allergy, **Y** or **N?** If yes, please explain the reaction.
______________________________________________________________

We are concerned that the recent research has revealed 30% of American children are obese with more than 50% of all US children being overweight. Please circle the most accurate description "**Never**, **Sometimes** or **Frequently**" of your child's daily food intake.

| **Never Sometimes Frequently** | **Never Sometimes Frequently** | **Never Sometimes Frequently** | **Never Sometimes Frequently** |
|---|---|---|---|
| **Non-Complex Carbohydrates**<br>Bread Products, Cereals, Pizza, Cakes, Cookies, Chocolate | **Complex Carbohydrates**<br>Fruits & Vegetables | **Protein**<br>Nuts, Seeds, Meats, Eggs, Fish | **Fats**<br>Dairy Products, Avocados, oils |

Please list the (3) most common foods eaten by your child each day.
______________________________________________________________

You might know that persistent use of antibiotics can lead to an early onset of gastrointestinal tract distress leading to overgrowth of intestinal yeast. Please list any and all prescription medications, including all antibiotic use that your child is presently taking and has taken on more than one occasion.
______________________________________________________________
______________________________________________________________

Each year a growing number of children are hospitalized due to acetaminophen and ibuprofen poisoning. Has your child had to take any products that contain these chemicals, **Y** or **N**? If yes, for what reason and for how long?__________________________
______________________________________________________________

***Physical Traumas:*** **(physical)**

Did mom experience any traumas during pregnancy (car accidents, falls etc…)?__________________________
______________________________________________________________

*Please turn over*

This beautiful bundle of joy was brought into the world at (circle one) home, birthing center or hospital_________________________ and my obstetrician/ midwife/ family physician that assisted was________________________. The total time of labor was________ and was via (circle all that may apply) a **natural vaginal birth** (no medication/ interventions) or a **vaginal birth with assistance** (induction, pain medication, forceps, vacuum extraction, other) or a **planned c-section** or an **emergency c-section** (if emergency please give details). ______________________________________________________________________________________________

______________________________________________________________________________________________

What was the position of the baby during delivery? Was there any evidence of birth trauma? (bruising, misshaped head, stuck in birth canal, excessively long birth, cord around neck or other…)____________________________________________________

______________________________________________________________________________________________

______________________________________________________________________________________________

How many hours of the day would you estimate your child is sitting in a car seat, bumbo® seat or baby bouncer? ________. OSHA estimates that a child sustains 1,500 spinal related traumas before age 5; on average how many falls does your child sustain a day? _________. These minor falls combined with sitting are often overlooked however they have a severe influence on your child's nervous system ultimately affecting his/her overall health.

Accidental trauma is the number one cause of injury to children in the United States each year. Please list any and all injuries experienced by your child, how they occurred and what action was taken to correct them. ___________________________________

______________________________________________________________________________________________

______________________________________________________________________________________________

***Thought Stressors: (emotional)***

Are there difficulties with lactation, **Y** or **N**? If yes, please explain: ______________________________________________

Any problems/concerns with bonding, **Y** or **N**? If yes, please explain: ___________________________________________

Any behavioral concerns, **Y** or **N**? If yes, please explain:____________________________________________________

Does your child experience any night terrors, sleepwalking, bedwetting, difficulty sleeping, **Y** or **N**? If yes, please explain: __________

______________________________________________________________________________________________

My child **Does** or **Does Not** attend daycare and they started when they were _________________ age.

Research has shown that children spend on average between 3 and 4 hours a day in front of or watching a screen (i.e., TV, tablets and video games). How much time does your child spends in front of a digital device per day? ___________________________________

Has your child been diagnosed with a behavioral disorder or learning disability, **Y** or **N**? If yes, please explain: ____________________

______________________________________________________________________________________________

I have read the HIPPA form and understand that my family's health information will not be shared with anyone without my consent.

______________________________________________
Signature

**Welcome to our place of hope!**
**We look forward to serving you and your family along this journey to greater health.**

______________________________
Reviewed by Doctor (Office use only)