

Pre-School History and Consent
3 years to 5 years

Today's date _____

Child's name _____ Birthdate _____ Sex _____

Address _____ City _____ Zip _____

Parent's names _____

Parent's phone Home# _____ Cell # _____ Work# _____

Siblings and ages _____

Who referred you to our office _____

Reason for today's visit _____

Does your child complain of pain or discomfort? Yes / No

If yes, when does this occur? _____

Was onset: Sudden / Gradual Is problem: Constant / Intermittent

Has your child ever had this problem before? _____

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

WHY WE CHECK CHILDREN

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.

AUTHORIZATION FOR CARE OF A MINOR

I hereby Authorize Dr. Webb to administer care as deemed necessary to my son/daughter.

Signed _____ Date _____

Witnessed _____ Date _____

AUTHORIZATION TO TAKE AND PUBLISH PHOTOGRAPHS

I, _____, Dr. Webb or another person authorized by him to take and publish photographs of my child, _____, for clinical records. Such photographs may be used in publications for the purpose of scientific and/or clinical research, chiropractic education, and the promotion of chiropractic health care when Dr. Webb deems such publication will benefit these goals.

I also understand I, nor my child, will be identified by name without additional authorization.

Printed name: _____

Signature: _____

Relationship: _____

Date: _____

Witness: _____

PRE-SCHOOL CASE HISTORY

3 years to 5 years

Vertebral Subluxation Assessment

1. Has your child been checked by a Doctor of Chiropractic? _____ Who? _____
Were x-rays taken? _____
Who is your regular pediatrician? _____

Experts around the world agree; the birth process as we know it may cause extensive neurological trauma, damage and even death to the infant.

2. Did you have an 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? _____
 - Was labor induced? _____ If yes, why? _____
 - What position did you deliver in: Squatting / On Back
 - Birth Trauma: Doctor assisted / Twisted, Pulling / Vacuum Extraction / Forceps
 - Newborn trauma (medical procedures and test) _____

Repeated studies are now informing us breast feeding develops strong and healthy immune, neurological and digestive systems.

3. Is your child being breastfed? Yes / No If no, for how long was baby breastfed? _____
- Was this decision supported by your health care professional? Yes / No

4. Do you have concerns about your child's diet? Yes / No
- How would you rate your child's diet? _____
 - What is your child's favorite food? _____
 - Does your child consume artificial sweeteners? Yes / No
 - Does your child have any food allergies? Yes / No _____
 - Does your child eliminate stools each day? Yes / No
 - Does your child have any persistent or intermittent skin rashes? Yes / No _____
 - Is your child receiving any vitamin supplements? Yes / No _____
 - 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 does your child usually eat for snacks? _____
 - How much cow's milk does your child drink each day? _____
 - What types of fast food does your child like? _____

5. Do you have any other concerns about your child's growth and development?

-
- Has your child had upper respiratory infections? Yes / No How often? _____
 - Does your child have asthma? Yes / No _____

- Does your child complain of back or neck pain? _____
- Does your child complain of pains in the arms or legs? Yes / No _____
- Does your child complain of headaches? Yes / No _____
- Has your child had any earaches? Yes / No At what age did this first occur? _____
- Do earaches tend to occur in the same ear? Yes / No Right / Left / Both
- Has your child had any other illnesses? Yes / No
- Please list illnesses with approximate date. _____
- How often has your child been treated with drugs? Yes / No
- Were you informed of their adverse reactions? Yes / No
- If it was an antibiotic, was your child cultured for its use? Yes / No
- Is your child currently on any medications? Yes / No
- Please list medications _____
- Has your child had any surgeries? Yes / No _____
- Has your child ever been to a hospital or emergency room for evaluation or treatment? _____

According to the National Safety Council, approximately 50% of children have fallen onto their heads during their first years of life. Another study reveals ¼ million children are injured on playgrounds

6. Can you recall any such jolts, falls, or traumas to your child? Yes / No
- Please describe any such injuries _____
 - Any fractures or dislocations? _____
 - Has your child ever fallen from a bicycle, skateboard, scooter, roller blades or similar? Yes / No
 - Has your child ever fallen down stairs or fallen from a significant height? Yes / No
 - Has your child ever been in a car accident or a near-miss? Yes / No
 - Has your child ever had any other trauma or injuries? Yes / No _____
 - Does your child ever bang his/her head repeatedly against a wall, bed or other object? Yes / No
 - What sports does your child play? Soccer/ football/Gymnastics/Karate/Hockey/Lacrosse/Basketball/Dance/Wrestling/Baseball/Other _____

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 effect from interfering with this process with artificial immunizations are just being uncovered.

7. Were you adequately informed of the risks of vaccinating your child? Yes / No
- Did your child experience any behavioral, emotional or physical changes within 3 months of any shots? Yes / No
 - Please describe _____
 - Was it reported to your doctor? Yes / No

8. Do you have any other questions or concerns you would like to discuss?
- _____
 - _____