inspire life
CHIROPRACTIC CENTER

Welcome!

Your first visit to our center is an opportunity for us to learn all about you and your family. It is time for you to share with us where you are now in your health & life, as well as what you would like to move toward.
And away we go!

Pediatric Chiropractic Vitality Inventory

Today's Date: _____

Personal Information

Legal Name:_____ Preferred Name:_____

Pronoun: _____ Sex: _____ Gender: _____

Age:_____ Date of Birth:_____ Height: _____Weight: _____

Parents' names: _____

Address: _____ City: _____ State:_____ Zip: _____

Home Phone: (___)_____Business Phone: (___)_____ Cell Phone: (___)_____

Email Addresses: _____ _____

Are parents ☐ Single ☐ Married/Partnered ☐ Divorced ☐ Widowed

# of Kids: _____ How many at home?_____ Names & Ages of Children:_____

_____

What are your child's hobbies, interests, & inspirations: _____

_____

How did you hear about us?

☐ Website ☐ Google ☐ Social Media ☐ Event

☐ Referral - Who can we thank for referring you? _____

☐ Other:_____

Let's find out why you're here...

What concerns do you feel Inspire Life Chiropractic Center can address for your child?_____

_____

Related to: ☐ Sports ☐ Auto ☐Fall ☐Chronic ☐Home Injury ☐Other:_____

Are these concerns affecting your child's quality of life? (please check all that apply)

☐Communication ☐ School ☐ Fitness/Sports ☐ Playing ☐ Walking

☐Eating ☐ Attention/Focus ☐ Daily Routing ☐ Sleep

Please describe how these concerns affect you child's quality of life?_____

_____

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Health Care Practitioner History

Has your child ever been to Chiropractor before? ☐ Yes ☐ No Name of DC: _____

How long was your child under care? _____ days _____ weeks _____ months _____ years

Date of last visit: _____ Why did you stop child's care? _____

Is your child under care of any other doctor or healthcare provider? (check all that apply)

☐ Medical Physician ☐ Naturopath ☐ Acupuncturist ☐ Homeopath
☐ Massage Therapist ☐ Psycotherapist ☐ Energy Healer ☐ Dentist

Reason: _____

_____

The primary system in the body which coordinates health is the Nervous System (NS). This system is comprised of three layers. The first layer is the spinal musculature encasing the spinal column. The second layer is the joints of the spine known as the vertebral column designed to surround and protect the delicate NS. The third, most important layer is the communication layer made up of the brain, spinal cord, and nerves. When unmanaged stressors add up over time, it not only affects layers one and two, but creates dysfunction and dis-ease in this vital system, leading to physical, chemical, and emotional causes and effects.

The information below will help us to see the types of PHYSICAL, EMOTIONAL, & CHEMICAL stresses you have been subjected to in your life, how they may relate to your present spinal, nerve & health status, & whether they may have caused neurospinal dysfunction.

Pregancy & Birth

During pregnancy, did the mother:

☐ Experience any significant illnesses, difficulties, or trauma? _____
☐ Take any drugs / medications (Rx or OTC)? _____
☐ Smoke or consume alcohol _____

Please rate the mother's general stress level during pregnancy: 1 2 3 4 5 6 7 8 9 10

The birth process can traumatize a baby's spine and cause damage to the neural spinal system. Please CHECK where and how your child was birthed.

☐ Home ☐ Natural ☐ Cord around neck ☐ Elective Caesarian section ☐ Forceps
☐ Hospital ☐ Breech ☐ Prolonged labor ☐ Emergency Caesarian section ☐ Vacuum
☐ Epidural ☐ Pitocin ☐ Drug induced labor ☐ Manual traction of the neck ☐ Episiotomy
☐ Other medications or complications: _____

_____

Was the delivery premature? ☐ No ☐ Yes Weeks: _____ Birth Weight: _____
Approximately how long did labor last? _____ hours

Please list reasons for any interventions / complications during labor & delivery: _____

_____

Please check all that apply to your baby's status immediately after birth:

☐ Jaundice ☐ Respiratory problems ☐ Broken bones: _____
☐ Feeding problems ☐ Displaced joints ☐ Other conditions: _____

APGAR Score: _____

Was or Is the baby breastfed? ☐ No ☐ Yes For how long? _____
Please describe your breastfeeding experience: _____

_____

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Physical Stress: Infancy & Childhood

The minor & often ignored repetitive physical traumas that we have endured are often too numerous to list. Please list the major traumas that you remember from your childhood up to the present.

Have you had any accidents due to any of the following? (check all that apply)

☐ Sports ☐ Automobile ☐ Bicycle ☐ Chronic ☐ Home Injury ☐ Other:

If yes, please list the type of injury & date: _____

Please check all that apply to your child & give any necessary or relevant details:

☐ Uncoordinated / Accident prone _____
☐ Has been hospitalized _____
☐ Had a severe trauma _____
☐ Been in an automobile accident _____
☐ Has fractured a bone or dislocated a joint _____
☐ Has/had a chronic illness _____
☐ Has had surgery _____

What physical activities does your child participate in? _____

Emotional Stress

It is difficult to separate the emotional stress in our life from the physical response that often occurs. Please indicate if you are currently experiencing (C), have experienced any of the following stressors in the past (P), or anticipate the possiblity of experiencing this stress in the future (F).

	C	P	F		C	P	F
Academic pressure	☐	☐	☐	Parents' divorce	☐	☐	☐
Lifestyle change	☐	☐	☐	Loss of a loved one	☐	☐	☐
Relocation	☐	☐	☐	Loss of a pet	☐	☐	☐
New Sibling	☐	☐	☐	Bullying	☐	☐	☐

Does your child have difficulty interacting with schoolmates or friends? ☐ Yes ☐ No

Have you or anyone else noticed that your child is nervous, twitches, shakes, or exhibits rocking behavior? ☐ Yes ☐ No

If so, please describe: _____

Chemical Stress: Childhood through Adult

Chemical stress can occur when a substance, that is toxic to the body, is breathed, injected, taken by mouth, or placed on the skin (e.g.: food allergies, drug reactions, exposure to chemicals in the air, etc.) The following will reveal exposures your child may have experienced.

Have you chosen to vaccinate your child? ☐ Yes ☐ No

If yes, were you aware of your other options? ☐ Yes ☐ No

Do you want more information about other options? ☐ Yes ☐ No

Pediatric Chiropractic Vitality Inventory

Please check all vaccinations your child has received & at what age they were administered:

☐ DPT ☐ MMR ☐ Polio ☐ Other: _____
☐ Chicken Pox ☐ Hepatitis ☐ Flu _____

Please describe any & all reactions to vaccine(s): _____

_____

Please check all that apply & provide any relevant details:

☐ Child exposed to second-hand smoke. Where? _____
☐ Has taken antibiotics. Explain. _____
☐ Currently taking medications. Explain. _____
☐ Currently taking supplements. Explain. _____
☐ Has allergies. Explain. _____
What treatments have you used? _____

_____

What would you like your child to gain at Inspire Life?

☐ Resolution & Prevention of a symptom or problem
☐ Prevention of future problems
☐ Healthier spine & Nervous system
☐ Continual progression in health & life
☐ Other: _____

Let's Make Sure We're on the Same Page...

When an individual or family seeks and is accepted into a program of **function-based** chiropractic care, it is essential for all parties to be working toward the same objectives. We have only one goal, and it is important that everyone understands both our objective and the methods we will use to move consistently toward that objective.

Your care in our center is not a substitute or alternative for, nor is it a preventive form of medicine. Medically-based care specializes in the ***diagnosis*** and ***treatment*** of specific symptoms, illness and disease. Our function-based chiropractic care specializes solely in helping people of all ages ensure that their spines and nervous systems are functioning as optimally as possible. This in turn allows their bodies to work the best they possibly can.

So while the natural result of optimal function is increased **health**, **wellness**, and an **overall improved quality of life**, we will not diagnose, treat, or attempt to cure any specific physical, mental, or emotional ailment, nor will we give advice about specific medical conditions or treatments.

If you are seeking care for the removal of a ***specific*** medical symptom or condition, we suggest you seek additional help from a symptom, illness, and disease oriented professional. We suggest this strategy if you feel that our functional-based approach will not be sufficient in progressively raising you to the levels of health, wellness, and quality of life you desire for yourself and your family.

I,_____, have read and understand the above statement and I hereby give permission for Dr. Mel Krug to continue with my child's and/or my initial consultation and assessment. I also agree to return at a later date to allow Dr. Krug to report her findings and recommendations to me. By agreeing to this, I am in no way obligated to follow the advice given to me in the report of findings.

Signature:_____ Date: _____

We sincerely thank you for choosing our center & for taking the time to honestly reflect upon & share your current level of health & well being, as well as your goals.

We look forward to helping you maximize your experience & expression of health & life!