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 LEAGAL 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 name in giving thanks for our 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 health challenge?

To what do you relate the cause?

Is this dysfunction getting progressively worse or staying the same? ___Yes ___No ___Same
If yes, 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 improve your child's 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!

Certain conditions arise when the body's nervous system is overwhelmed and unable to adapt to stressors (Traumas, Toxins and Thoughts) of our lifestyles. Please check any of the following that apply now or occurred in the past.

____ Allergies	____Frequent colds/ congestion	____Upper respiratory Infections	____Asthma
____Ear infections	____Infected/sore throat	____Tonsillitis	____Laryngitis
____ Sensory processing disorder	____Reflux/spitting up	____U-tract infections	____Poor appetite
____Poor digestion/ (constipation/diarrhea)	____Eye infection	____Eczema/psoriasis/ other skin rashes	____ADD/ADHD
____Irregular sleep patterns	____Night terrors	_____Bed wetting	____Headache
____Anxiety	____Mood swings	____Bruising	Other:

"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)**

You might know 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 antibiotics, which your child is presently taking or 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 of these products? If yes, for what reason and for how long?

_____

_____

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** and **Frequently**" of your child's daily food intake.

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

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

_____

Does your child experience a food or drink intolerance, **Y** or **N?**
What type of intolerance?_____

_____

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

_____

Is your child currently taking any supplements, **Y** or **N?** If yes please list:

_____

Physical Traumas: **(physical)**

Research shows that poor posture leads to weakening of the spine as well as increased stress on the nervous system that can adversely affect your child's overall health. How do you rate your child's posture?

Poor 1 2 3 4 5 6 7 8 9 10 Excellent

Please check any of the following sporting activities that your child is involved in.

____ Football	____ Lacrosse	____ Soccer	____Track/Field
____ Bowling	____ Tennis	____ Hockey	____ Volleyball
____Baseball/Softball	____ Skateboarding	____ Golfing	____ Skiing/Snowboarding
____ Gymnastics/Dance/Ballet	____ BMX/Motorcross	____ Swimming	Other_____

Please turn over

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 any behavioral concerns? _____

_____

Does your child experience any night terrors, sleepwalking, bedwetting, difficulty sleeping? _____

_____

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 any 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)