



Welcome to Sugar Hill Family Chiropractic

♥ Children's Health Survey ♥

Child's Name _____ Age _____ Today's Date ____/____/____

Date of Birth ____/____/____ Birth Weight _____ # Of Siblings _____

Mother's Name _____ Father's Name _____

Phone (Home) _____ (Work) _____

Address _____ City _____ State _____ Zip _____



"As the twig is bent so grows the tree"

Keep the spine aligned and free of interference from the start and help your child to avoid the problems that you have today!!!

<u>During pregnancy, had any of the following occurred?</u>	YES	NO	COMMENTS
Physical trauma (accidents, falls, etc.)?	_____	_____	_____
Emotional stress?	_____	_____	_____
Have ultrasound, amniocentesis (other tests)?	_____	_____	_____
Smoke tobacco / Drink alcohol?	_____	_____	_____
Consume products containing nutrasweet/aspartame	_____	_____	_____
Take any other drugs or medications?	_____	_____	_____
<u>Birth Process...</u>			
Hospital Birth?	_____	_____	_____
Induced labor?	_____	_____	_____
Drugs given during labor/delivery?	_____	_____	_____
Difficult delivery or Cesarean?	_____	_____	_____
Breech Pregnancy/Delivery?	_____	_____	_____
Forceps or vacuum distracter used?	_____	_____	_____
Baby pulled by doctor/midwife during delivery?	_____	_____	_____
Presence of Jaundice(yellow) or Cyanosis (blue)?	_____	_____	_____
<u>Early Development...</u>			
Falls from a height?	_____	_____	_____
Ever been treated on an emergency basis?	_____	_____	_____
Breast fed? How long?	_____	_____	_____
Given medication for any reason?	_____	_____	_____
Spent time in a walker or door swing?	_____	_____	_____



Mark each of the following that have been diagnosed at any time in the present or the past

- | | | | |
|---|---------------------------------------|--|-------------------------------------|
| <input type="checkbox"/> Measles | <input type="checkbox"/> Ecema | <input type="checkbox"/> Cancer | <input type="checkbox"/> Meningitis |
| <input type="checkbox"/> Mumps | <input type="checkbox"/> Diabetes | <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> HIV + |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Allergies | <input type="checkbox"/> Asthma | <input type="checkbox"/> Eating |
| <input type="checkbox"/> Small Pox | <input type="checkbox"/> TB | <input type="checkbox"/> Anemia | <input type="checkbox"/> Disorder |
| <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Colic | <input type="checkbox"/> MS |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Hypersensitivity | <input type="checkbox"/> Whooping | <input type="checkbox"/> Learning | <input type="checkbox"/> Bronchitis |
| <input type="checkbox"/> Permanant | <input type="checkbox"/> Cough | <input type="checkbox"/> Disability/Disorder | |
| <input type="checkbox"/> Disability | <input type="checkbox"/> Mononuclosis | <input type="checkbox"/> Lymes Disease | <input type="checkbox"/> Other |

Comments/Explanation (Please include dates and who or where diagnosed)

*Reason for consulting this office? _____

Has this ever occurred before? _____ When? _____

Has anyone in your family ever experienced this or anything similar before? _____

What makes it better? _____

What makes it worse? _____

Is this child currently under a physicians care for this or any other reason? _____

I hereby authorize this clinic and it's doctors to administer care as they so deem necessary to my son/daughter/ward. I realize that I am responsible for all fees charged by this clinic and that I will pay for all services as they are performed. X-rays remain the property of this clinic.

Signed: _____

Date: _____



Vaccination History (Please list) _____

Any reactions after vaccinations (minor or major)
 (ie. high pitched screaming, long period of sleep or crying, reversal
 delay in learning progression, etc.—within 2 years)

Childhood to Present...	YES	NO	COMMENTS
Physical Trauma			
Surgeries or Medical procedures?	_____	_____	_____
Fractures or dislocations?	_____	_____	_____
Accidents (car, falls, ect.)?	_____	_____	_____
Sports injuries?	_____	_____	_____
Difficulty exercising (or specific motions)?	_____	_____	_____
Exercise: _____ Regularly	_____ Sporatically	_____ Rarely	_____ Never
Sleep posture: _____ Restless	_____ Stomach	_____ Side	_____ Back

Date of last visit to M.D. _____ Purpose _____
 Family History _____



The Nervous System is the master system of the body. It controls and coordinates all functions. Symptoms are warning signals that the Nervous System is not functioning properly. Please answer all of the following in order to help us identify the source of these problems.

The following are possible signs of Vertebral Subluxation Complex
 (Please circle all that Apply)

- *DIZZINESS *HEADACHES *FREQUENT COLDS *CHRONIC EARACHE/INFECTION
- *IRRITABILITY *NECK/BACK PAIN *ANEMIA *POOR APPETITE *ALLERGIES
- *GROWING PAINS *LEARNING DISORDER *DIFFICULTY CONCENTRATING
- *BEHAVIORAL PROBLEMS *CONSTIPATION *DIARRHEA *DIGESTIVE PROBLEM
- *CONVULSIONS *WALKING/BALANCING DIFFICULTIES *BED WETTING
- *PARALYSIS *EYE DISORDERS *DIFFICULTY SLEEPING *HEART TROUBLE
- *DIABETES *HYPERACTIVITY *FAINTING *SINUS TROUBLE *DYSLEXIA
- *SCOLIOSIS *LACTOSE INTOLERANCE *FATIGUE/WEAKNESS



X-RAY AND TREATMENT CONSENT FORM

I, _____, give my consent to Sugar Hill Family
Chiropractic to perform any examination, treatments and x-rays that are deemed
necessary.

I agree to be responsible for the full amount of the services rendered.

Signed _____

Dated _____