

Welcome to Foothills Chiropractic, PA

Name: _____ Nickname: _____ Current age: _____ Date of Birth: _____

Child's Home Address _____ City _____ State _____ Zip _____

Parent #1 _____ Phone (h) _____ (work) _____ (cell) _____

Parent #2 _____ Phone (h) _____ (work) _____ (cell) _____

Parent's Email _____

Child's Sex at Birth : Male Female Pronoun: _____

Purpose of the appointment with doctor today: _____

Has child ever received chiropractic care? (Please circle) Yes No Referred by _____

If Child was adopted:

Adoption Information

Child's age when adopted _____ Date of Adoption _____

Known health history of child _____

(Use back of page for additional information as needed)

Pregnancy Information

Pregnancy History: _____

Pre-natal Supplements? Yes No Omega 3 Supplement? Yes No Pro-biotic Supplement? Yes No

Organic Diet? Yes No Any Prolonged Emotional Stress During Pregnancy? Yes No

Any Loss Suffered During Pregnancy? (Example: death, loss of job or pet) Yes No Comment: _____

Medications taken during pregnancy? _____

Any problems during pregnancy and/or labor? (Use back of page for additional information as needed)

Delivery/Birth History: _____

Birth Information

Birth Weight: _____ Birth Length: _____ Epidural: Yes No

Type of Birth: Vaginal Forceps Breech Cesarean Home Birthing Center Hospital

Apgar Scores: _____ Jaundice (yellow) at Birth? Yes No Cyanosis (blue) Yes No

Congenital Anomalies/Defects: _____

Infant Feeding: Breast For how long? _____ Bottle Which Formula? _____

Any issues with feeding? _____

Number of hours child sleeps daily: _____ Quality of Sleep: Good Fair Poor

Has child had any vaccinations? _____

Number of Siblings: _____ Siblings Name, Age and Sex: _____

Date of last visit to any doctor: _____ Reason for that visit: _____

Has child ever been treated on an emergency basis? _____

At what age did child respond to sound: _____ Crawl: _____ Follow object with eyes: _____

Hold head up: _____ Stand: _____ Sit Alone: _____ Walk Alone: _____

Current Health Habits

| Yes | No | | Comments | Notes by Doctor |
|-----------------------------------|--------------------------|--|----------|-----------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Diet (Eating healthy foods)? | _____ | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Has child been in any accidents? | _____ | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Exercise Regularly? | _____ | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Hobbies/Sports injuries? | _____ | _____ |
| Sleeping Posture: | | <input type="checkbox"/> Side <input type="checkbox"/> Stomach <input type="checkbox"/> Back (Comment) | _____ | _____ |
| How are things going at school? | | (Comment) | _____ | _____ |
| Performance: | | <input type="checkbox"/> Good <input type="checkbox"/> Poor (Comment) | _____ | _____ |
| Interaction: | | <input type="checkbox"/> Good <input type="checkbox"/> Poor (Comment) | _____ | _____ |
| Does child have emotional stress? | | Family <input type="checkbox"/> School <input type="checkbox"/> Other _____ | _____ | _____ |

Any Present Complaints: _____

Pain or Problem started on _____ Feels like: _____ Sharp Dull Ache Burns Numbness

Is condition interfering with school? _____ Sleep? _____ Routine? _____ Other? _____

Is this condition getting progressively worse? _____ Using any home remedies? _____

⇒ Please note **ANY** of the following signals that have presented, even if you feel they are unrelated:

| | | |
|---|---|--|
| <Under-Aroused> | <Un-Stable> | <Over -Aroused> |
| <input type="checkbox"/> Poor Attention | <input type="checkbox"/> Migraines | <input type="checkbox"/> Cold hands |
| <input type="checkbox"/> Impulsive | <input type="checkbox"/> Headaches | <input type="checkbox"/> Cold feet |
| <input type="checkbox"/> Easily Distracted | <input type="checkbox"/> Seizures | <input type="checkbox"/> Tight Muscles |
| <input type="checkbox"/> Disorganized | <input type="checkbox"/> Sleepwalking | <input type="checkbox"/> Teeth grinding |
| <input type="checkbox"/> Depressed | <input type="checkbox"/> Hot flashes | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Lacking motivation | | <input type="checkbox"/> Heart Palpitations |
| <input type="checkbox"/> Poor Concentration | <input type="checkbox"/> Food sensitivities | <input type="checkbox"/> Restless Sleep |
| <input type="checkbox"/> Spaciness | <input type="checkbox"/> Bed wetting | <input type="checkbox"/> Poor expression of emotions |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> poor immune system |
| <input type="checkbox"/> Low Pain Threshold | <input type="checkbox"/> Bipolar Disorder | <input type="checkbox"/> Racing Mind |
| <input type="checkbox"/> Difficulty waking up | <input type="checkbox"/> Mood Swings | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Worry | <input type="checkbox"/> Panic Attacks | <input type="checkbox"/> Accelerated Aging |
| <input type="checkbox"/> Irritable | | <input type="checkbox"/> Irritable Bowel |
| <input type="checkbox"/> Low Energy | | |
| | <Exhausted> | |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Chronic Fatigue Syndrome | <input type="checkbox"/> Epstein-Barr Syndrome |
| <input type="checkbox"/> Eczema or Skin problems | <input type="checkbox"/> Pins & Needles in Legs or Arms | <input type="checkbox"/> Buzzing in Ears |
| <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Loss of Smell or Taste | <input type="checkbox"/> Dyslexia |
| <input type="checkbox"/> Numbness in Fingers & Toes | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Dizziness or Fainting |
| <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Face Flushed |
| <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Urinary Infections | <input type="checkbox"/> Speech Difficulty |
| | | <input type="checkbox"/> Vision Problems |
| | | <input type="checkbox"/> Loss of Memory |
| | | <input type="checkbox"/> Sinus Problems |
| | | <input type="checkbox"/> Bladder Problems |
| | | <input type="checkbox"/> ADHD or ADD |

Has child been under drug and medical care? _____

What medications does the child take? _____

How long has child been taking them? _____ Side effects noticed: _____

The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine my child for further evaluation:

Signature (Parent or Guardian)

Printed name of person completing this form

Date

SYSTEMS SURVEY FORM



Patient _____ Doctor _____ Date _____

Birth Date ____ / ____ / ____ Approx Weight _____ Vegetarian: Yes .. No ..

INSTRUCTIONS: Number only the boxes which apply to you. Leave blank if you don't have the problem.

* Write 1 in the box for MILD symptoms (occurs rarely).

* Write 2 in the box for MODERATE symptoms (occurs several times a month).

* Write 3 in the box for SEVERE symptoms (occurs almost constantly).

Please do not use checkmarks in the boxes - fill in the boxes with a number or leave blank!

GROUP 1

- | | | |
|--|---|--|
| 1 <input type="checkbox"/> Acid foods upset | 8 <input type="checkbox"/> Gag easily | 15 <input type="checkbox"/> Appetite reduced |
| 2 <input type="checkbox"/> Get chilled often | 9 <input type="checkbox"/> Unable to relax; startles easily | 16 <input type="checkbox"/> Cold sweats often |
| 3 <input type="checkbox"/> "Lump" in throat | 10 <input type="checkbox"/> Extremities cold, clammy | 17 <input type="checkbox"/> Fever easily raised |
| 4 <input type="checkbox"/> Dry mouth-eyes-nose | 11 <input type="checkbox"/> Strong light irritates | 18 <input type="checkbox"/> Neuralgia-like pains |
| 5 <input type="checkbox"/> Pulse speeds after meal | 12 <input type="checkbox"/> Urine amount reduced | 19 <input type="checkbox"/> Staring, blinks little |
| 6 <input type="checkbox"/> Keyed up - fail to calm | 13 <input type="checkbox"/> Heart pounds after retiring | 20 <input type="checkbox"/> Sour stomach often |
| 7 <input type="checkbox"/> Cut heals slowly | 14 <input type="checkbox"/> "Nervous" stomach | |

GROUP 2

- | | | |
|--|--|--|
| 21 <input type="checkbox"/> Joint stiffness on arising | 29 <input type="checkbox"/> Digestion rapid | 37 <input type="checkbox"/> "Slow starter" |
| 22 <input type="checkbox"/> Muscle-leg-toe cramps at night | 30 <input type="checkbox"/> Vomiting frequent | 38 <input type="checkbox"/> Get "chilled" infrequently |
| 23 <input type="checkbox"/> "Butterfly" stomach, cramps | 31 <input type="checkbox"/> Hoarseness frequent | 39 <input type="checkbox"/> Perspire easily |
| 24 <input type="checkbox"/> Eyes or nose watery | 32 <input type="checkbox"/> Breathing irregular | 40 <input type="checkbox"/> Circulation poor, sensitive to cold |
| 25 <input type="checkbox"/> Eyes blink often | 33 <input type="checkbox"/> Pulse slow; feels "irregular" | 41 <input type="checkbox"/> Subject to colds, asthma, bronchitis |
| 26 <input type="checkbox"/> Eyelids swollen, puffy | 34 <input type="checkbox"/> Gagging reflex slow | |
| 27 <input type="checkbox"/> Indigestion soon after meals | 35 <input type="checkbox"/> Difficulty swallowing | |
| 28 <input type="checkbox"/> Always seems hungry; feels "lightheaded" often | 36 <input type="checkbox"/> Constipation, diarrhea alternating | |

GROUP 3

- | | | |
|--|--|---|
| 42 <input type="checkbox"/> Eat when nervous | 49 <input type="checkbox"/> Heart palpitates if meals missed or delayed | 53 <input type="checkbox"/> Crave candy or coffee in afternoons |
| 43 <input type="checkbox"/> Excessive appetite | 50 <input type="checkbox"/> Afternoon headaches | 54 <input type="checkbox"/> Moods of depression - "blues" or melancholy |
| 44 <input type="checkbox"/> Hungry between meals | 51 <input type="checkbox"/> Overeating sweets upsets | 55 <input type="checkbox"/> Abnormal craving for sweets or snacks |
| 45 <input type="checkbox"/> Irritable before meals | 52 <input type="checkbox"/> Awaken after few hours sleep - hard to get back to sleep | |
| 46 <input type="checkbox"/> Get "shaky" if hungry | | |
| 47 <input type="checkbox"/> Fatigue, eating relieves | | |
| 48 <input type="checkbox"/> "Lightheaded" if meals delayed | | |

GROUP 4

- | | | |
|---|--|--|
| 56 <input type="checkbox"/> Hands and feet go to sleep easily, numbness | 63 <input type="checkbox"/> Get "drowsy" often | 68 <input type="checkbox"/> Bruise easily, "black and blue" spots |
| 57 <input type="checkbox"/> Sigh frequently, "air hunger" | 64 <input type="checkbox"/> Swollen ankles, worse at night | 69 <input type="checkbox"/> Tendency to anemia |
| 58 <input type="checkbox"/> Aware of "breathing heavily" | 65 <input type="checkbox"/> Muscle cramps, worse during exercise; get "charley horses" | 70 <input type="checkbox"/> "Nose bleeds" frequent |
| 59 <input type="checkbox"/> High altitude discomfort | 66 <input type="checkbox"/> Shortness of breath on exertion | 71 <input type="checkbox"/> Noises in head, or "ringing in ears" |
| 60 <input type="checkbox"/> Opens windows in closed rooms | 67 <input type="checkbox"/> Dull pain in chest or radiating into left arm, worse on exertion | 72 <input type="checkbox"/> Tension under the breastbone, or feeling of "tightness", worse on exertion |
| 61 <input type="checkbox"/> Susceptible to colds and fevers | | |
| 62 <input type="checkbox"/> Afternoon "yawner" | | |

SYSTEMS SURVEY FORM - PAGE 2

GROUP 5

- | | | |
|--|---|--|
| 73 <input type="checkbox"/> Dizziness 74 <input type="checkbox"/> Dry skin 75 <input type="checkbox"/> Burning feet 76 <input type="checkbox"/> Blurred vision 77 <input type="checkbox"/> Itching skin and feet 78 <input type="checkbox"/> Excessive falling hair 79 <input type="checkbox"/> Frequent skin rashes 80 <input type="checkbox"/> Bitter, metallic taste in mouth in mornings 81 <input type="checkbox"/> Bowel movements painful or difficult 82 <input type="checkbox"/> Worrier, feels insecure | 83 <input type="checkbox"/> Feeling queasy; headache over eyes 84 <input type="checkbox"/> Greasy foods upset 85 <input type="checkbox"/> Stools light colored 86 <input type="checkbox"/> Skin peels on foot soles 87 <input type="checkbox"/> Pain between shoulder blades 88 <input type="checkbox"/> Use laxatives 89 <input type="checkbox"/> Stools alternate from soft to watery 90 <input type="checkbox"/> History of gallbladder attacks or gallstones | 91 <input type="checkbox"/> Sneezing attacks 92 <input type="checkbox"/> Dreaming, nightmare type bad dreams 93 <input type="checkbox"/> Bad breath (halitosis) 94 <input type="checkbox"/> Milk products cause distress 95 <input type="checkbox"/> Sensitive to hot weather 96 <input type="checkbox"/> Burning or itching anus 97 <input type="checkbox"/> Crave sweets |
|--|---|--|

GROUP 6

- | | | |
|--|---|---|
| 98 <input type="checkbox"/> Loss of taste for meat 99 <input type="checkbox"/> Lower bowel gas several hours after eating 100 <input type="checkbox"/> Burning stomach sensations, eating relieves | 101 <input type="checkbox"/> Coated tongue 102 <input type="checkbox"/> Pass large amounts of foul-smelling gas 103 <input type="checkbox"/> Indigestion 1/2 - 1 hour after eating; may be up to 3-4 hrs. | 104 <input type="checkbox"/> Mucous colitis or "irritable bowel" 105 <input type="checkbox"/> Gas shortly after eating 106 <input type="checkbox"/> Stomach "bloating" after eating |
|--|---|---|

GROUP 7

- | | | |
|---|---|---|
| <p>(A)</p> 107 <input type="checkbox"/> Insomnia 108 <input type="checkbox"/> Nervousness 109 <input type="checkbox"/> Can't gain weight 110 <input type="checkbox"/> Intolerance to heat 111 <input type="checkbox"/> Highly emotional 112 <input type="checkbox"/> Flush easily 113 <input type="checkbox"/> Night sweats 114 <input type="checkbox"/> Thin, moist skin 115 <input type="checkbox"/> Inward trembling 116 <input type="checkbox"/> Heart palpitates 117 <input type="checkbox"/> Increased appetite without weight gain 118 <input type="checkbox"/> Pulse fast at rest 119 <input type="checkbox"/> Eyelids and face twitch 120 <input type="checkbox"/> Irritable and restless 121 <input type="checkbox"/> Can't work under pressure | <p>(C)</p> 137 <input type="checkbox"/> Failing memory 138 <input type="checkbox"/> Low blood pressure 139 <input type="checkbox"/> Increased sex drive 140 <input type="checkbox"/> Headaches, "splitting or rending" type 141 <input type="checkbox"/> Decreased sugar tolerance | <p>(E)</p> 150 <input type="checkbox"/> Dizziness 151 <input type="checkbox"/> Headaches 152 <input type="checkbox"/> Hot flashes 153 <input type="checkbox"/> Increased blood pressure 154 <input type="checkbox"/> Hair growth on face or body (female) 155 <input type="checkbox"/> Sugar in urine (not diabetes) 156 <input type="checkbox"/> Masculine tendencies (female) |
| <p>(B)</p> 122 <input type="checkbox"/> Increase in weight 123 <input type="checkbox"/> Decrease in appetite 124 <input type="checkbox"/> Fatigue easily 125 <input type="checkbox"/> Ringing in ears 126 <input type="checkbox"/> Sleepy during day 127 <input type="checkbox"/> Sensitive to cold 128 <input type="checkbox"/> Dry or scaly skin 129 <input type="checkbox"/> Constipation 130 <input type="checkbox"/> Mental sluggishness 131 <input type="checkbox"/> Hair coarse, falls out 132 <input type="checkbox"/> Headaches upon arising, wear off during day 133 <input type="checkbox"/> Slow pulse, below 65 134 <input type="checkbox"/> Frequency of urination 135 <input type="checkbox"/> Impaired hearing 136 <input type="checkbox"/> Reduced initiative | <p>(D)</p> 142 <input type="checkbox"/> Abnormal thirst 143 <input type="checkbox"/> Bloating of abdomen 144 <input type="checkbox"/> Weight gain around hips or waist 145 <input type="checkbox"/> Sex drive reduced or lacking 146 <input type="checkbox"/> Tendency to ulcers, colitis 147 <input type="checkbox"/> Increased sugar tolerance 148 <input type="checkbox"/> Women: menstrual disorders 149 <input type="checkbox"/> Young girls: lack of menstrual function | <p>(F)</p> 157 <input type="checkbox"/> Weakness, dizziness 158 <input type="checkbox"/> Chronic fatigue 159 <input type="checkbox"/> Low blood pressure 160 <input type="checkbox"/> Nails weak, ridged 161 <input type="checkbox"/> Tendency to hives 162 <input type="checkbox"/> Arthritic tendencies 163 <input type="checkbox"/> Perspiration increase 164 <input type="checkbox"/> Bowel disorders 165 <input type="checkbox"/> Poor circulation 166 <input type="checkbox"/> Swollen ankles 167 <input type="checkbox"/> Crave salt 168 <input type="checkbox"/> Brown spots or bronzing of skin 169 <input type="checkbox"/> Allergies - tendency to asthma 170 <input type="checkbox"/> Weakness after colds, influenza 171 <input type="checkbox"/> Exhaustion - muscular and nervous 172 <input type="checkbox"/> Respiratory disorders |

SYSTEMS SURVEY FORM - PAGE 4

Please list any medications you are taking:

No Medications

Please list any vitamins, herbs, or supplements you are taking:

No Vitamins

Please list any allergies you have:

No Allergies

Please list any surgeries you have had in the past 12 months:

No Recent Surgeries

Please list any other surgeries or medical procedures you have had:

No Other Surgeries

TO BE COMPLETED BY DOCTOR

Blood Pressure: Recumbent _____ Standing _____

Pulse: Recumbent _____ Standing _____

Hema-Combistix Urine Readings: pH _____ Albumin % _____ Glucose % _____

Occult Blood _____ pH of Saliva _____ pH of Stool Specimen _____

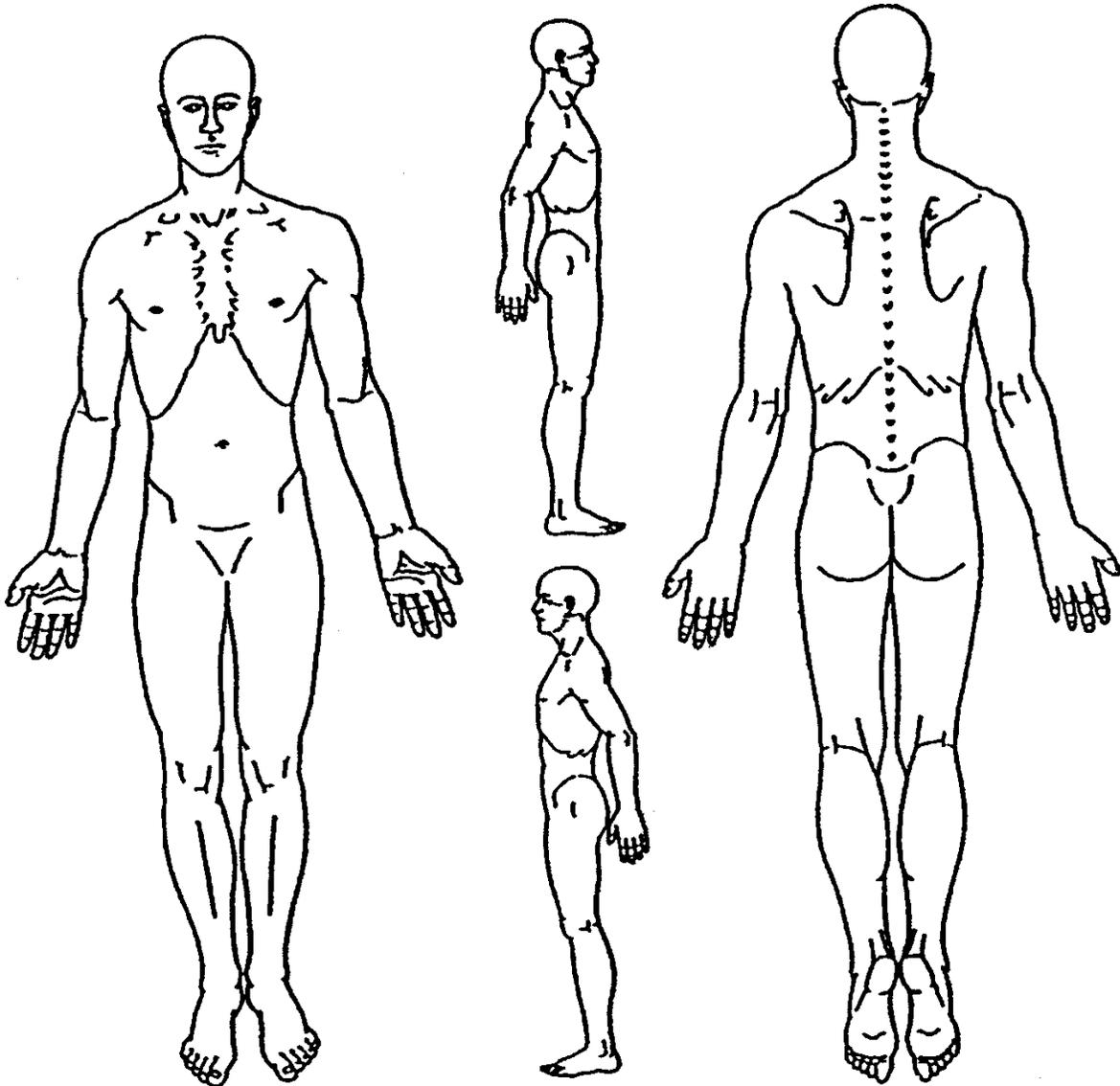
Blood Clotting Time _____ Hemoglobin _____ Blood Type _____ Weight _____

SYSTEMS SURVEY FORM - PAGE 5

Use the letters listed below to indicate the type and location of your pain and sensations:

KEY

- A = ACHE
- B = BURNING
- S = STABBING
- N = NUMBNESS
- P = PINS & NEEDLES
- O = OTHER



PLEASE INDICATE THE LEVEL OF PAIN YOU ARE EXPERIENCING

NO PAIN

SEVERE PAIN

0 1 2 3 4 5 6 7 8 9 10

Patient Signature _____ Date _____