

Enhance Your Life Chiropractic  
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Children's Health Evaluation (Newborn – 14 years)

Today's Date \_\_\_\_\_  
Child's Name \_\_\_\_\_ Birth date \_\_\_\_\_  
Parents Name(s) \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_  
Phone \_\_\_\_\_

Thank you for choosing our office!

Current Health Concern

Do you have any current health concerns for your child? Please describe.

\_\_\_\_\_  
\_\_\_\_\_

How does this seem to affect their quality of life, play, temper, mood?

\_\_\_\_\_  
\_\_\_\_\_

If no current specific health concern how would you grade their overall quality of life?

Poor  Fair  Good  Excellent

Section I - Pre-Natal Care

Please list the type(s) of prenatal care you had and any prenatal procedures (for example Ultrasound, Pelvic Exams, and Amniocentesis).

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please list any medications taken during pregnancy (prescription or OTC).

\_\_\_\_\_  
\_\_\_\_\_

Please describe your physical health during your pregnancy.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
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Please describe your emotional/mental health during your pregnancy.

\_\_\_\_\_  
\_\_\_\_\_

## Section II - The Delivery

Did your child's birth go as you planned? Please explain.

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Where did you have his/her birth?

- Hospital
- Birth Center
- Home

Where any of these birth interventions used?

- Fetal Monitor
- Ultrasound during delivery
- Forceps/Forcible Extraction
- Suction
- Epidural
- Episiotomy
- C-Section
- None of These

## Section III - Early Days

Describe how your baby responded in the first few hours or days.

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## Section IV - Baby stuff

Did your baby...

- Nurse
- Bottle-feed
- Both

Have there been any falls from the bed or crib or other high places?

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Where there any serious falls or accidents while learning to crawl, walk, etc.?

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Section V - Health Care Choices

Have you consulted any health care providers, and what was the reason for the consultation?

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List any drugs or remedies the child has received or currently receives. Please list over-the-counter and prescription drugs, Homeopathic remedies, herbs, etc. and the reason for giving them.

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Vaccination Choices

Type and Age

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Type and Age

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Type and Age

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Type and Age

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Type and Age

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Section VI - Health Goals

Please describe your hopes or goals for your child receiving care in this office.

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Is there anything else we should know about your child?

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