Welcome to The Center for Optimal Living!

Lifelong health and vitality is our birthright. Few of us know how we lose it and how to get it back.

Your child's health and well-being is their expression of life. Even newborns experience physical, chemical, emotional and mental experiences (stressors) that can accumulate on a daily basis, interfering and challenging your child's expression of life. Our goal is to locate and address the interference to their potential with extremely gentle tonal adjustments allowing your child's nerve system and body to begin healing and reorganizing from the inside-out and realize a greater expression of life.

Knowledge about your child will help in understanding who they are, why they are coming to the Centre, what you are expecting and how we may best assist your family towards Optimal Living.

Please take a couple of minutes to document your child's Vital Information. If you have any questions, please do not hesitate to ask one of the Centre's staff.

The Centre for Optimal Living is pleased to serve your family. We are committed to empowering all of you to express your full life potential so you may experience the highest expression of health, wellbeing & Optimal Living.

CHILD INITIAL QUESTIONNAIRE

First Name _____ Last Name _____

Address _____

City _____
Province _____ Postal Code_____
Email Address _____
Home Phone _____ Business Phone_____

Date of Birth D_____/M_____/Y_____

Name of parents _____
Name of siblings and ages_____

Have you seen a chiropractor before? No___ If so when?_____
_____

Does your family see a chiropractor? _____

What would you like your child to receive from care in this office?
_____

What is your level of commitment to you and your child's life and well-being?_____

How did you find out about the Centre for Optimal Living?
_____
_____

Is there anything about your child's Nerve System and Spine or health we should know about?_____
_____

Additional Comments:_____
_____

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I hereby authorize and consent to the chiropractic evaluation and care of my child. Parent/Guardian Signature_____
Date_____
Witnessed Signature_____

History of birth and Labour
Name of Obstetrician/Midwife_____
Name of MD/Pediatrician_____

Type of birth? Cephalic (head first)_____
Breech (feet first)_____
Occiput Posterior (facing forward)_____
Location of birth? _____
Birth Assistants? (MD, Midwife, Doula)_____
Any assistance required during birth? (Forceps, Vacuum extraction, Cesarean)_____
Any Complications during birth? _____
_____

What was the child's gestational age at birth?_____weeks
Birth weight_____ Birth length_____
Congenital anomalies/defects present?_____

Was your child subjected to any of the following?
Silver Nitrate eye drops_____ Incubation (how long)_____
Vitamin K injection_____ Hepatitis injection_____
Separation from mother (how long)_____

Was your child alert and responsive within 12 hours of delivery?
Explain_____
_____
Mother's position during labour (back, side, sitting, standing, other)_____
_____
Was labour induced? _____

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Did the mother receive any drugs before, during, or after the birth process? (Epidural, Morphine, other)_____

_____

Did the mother have an episiotomy?_____
Duration of the labour and delivery_____

Growth and Development
At what age did your child:
Follow an object_____ Respond to sound_____
Hold up head_____ Vocalize_____
Sit unassisted_____ Teethe_____
Crawl_____ Walk_____

Do you consider your child's sleeping pattern normal?
Explain_____
Any health problems on the mother's side of the family? (cancer, diabetes, heart disease, etc.)_____

_____

On the father's side_____

_____

With siblings_____

_____

Chemical stressors
Any trauma/illness during the pregnancy?_____

_____

During pregnancy did the mother:
Cigarette Smoke (first or second hand, if so how much)_____
Consume Alcohol (if so how much) _____
Take supplements (if so please list)_____
Take drugs (if so please list) _____
Receive ultrasounds or other radiation_____
Receive any invasive procedures during the pregnancy (amniocentesis, etc.)_____

Was your child breast fed? (until what age)_____
Introduced formula at what age?_____
Introduced cows milk at what age?_____

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Introduced solid foods at what age?
(types)_____

Please list your child's history of antibiotic use and types

_____

_____

Please list your child's history of vaccinations and the age given_____

_____

Reason for vaccinations?_____
Any negative reactions?_____
Any smokers in the home? (Please list)_____
Any pets in the home? (Please list)_____

Psychosocial stressors
Did the mother have any problems with lactation?_____

_____

Any problems with bonding with you child?_____
Any behavioral problems?_____
Number of hours your child sleeps?_____
Any night terrors, sleep walking, difficulty sleeping?_____

_____

Average number of hours your child watches television each week, if any

_____

Do you feel that your child's social and emotional development is normal for their age? (Please explain)_____

_____

Physical stressors
Any traumas for the mother during pregnancy? (falls, accidents, etc.)_____

_____

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Any evidence of birth trauma to your child? Check all that apply:

Bruising___ **Stuck in birth canal___**

Odd shaped head___ **Respiratory depression___**

Fast or excessively long birth___ **Cord around neck___**

Any child falls from couches, beds, change tables, etc?_____

_____

Any child traumas resulting in bruises, fractures, or stitches?_____

_____

Any child hospitalizations or surgeries?_____

Any sports participation and age began? (list sports and number of hours each week)_____

_____

Approximate hours of playtime each week_____

Is a school backpack used? (Heavy or Light)_____

Additional comments:_____

_____

_____

_____

_____

Thank you for your time and energy. We look forward to serving your family.