



VAN FAMILY CHIROPRACTIC

DR. ERIN VAN VELDUIZEN

Child History Form

Child's Name _____ Age _____ Date of Birth ____ - ____ - ____

Parent/Guardian Names _____

Address _____

Street or PO Box

City

State

Zip

Phone (Home) _____ (Work) _____ (Cell) _____

E-Mail Address _____ Sex: M ___ F ___ Height: _____ Weight: _____

How many siblings? ___ Names & Ages of Siblings: _____

Referred to Dr. Erin by: _____

Purpose for Visit: _____ Have you seen any other Dr. for this? Y N

Describe Treatment given: _____

Check any conditions your child has suffered from:

- | | | |
|--|--|---------------------------------------|
| <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Chronic Colds | <input type="checkbox"/> Digestive Problems | <input type="checkbox"/> Colic |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Allergies | <input type="checkbox"/> ADD/ADHD |
| <input type="checkbox"/> Recurring Fevers | <input type="checkbox"/> Bed Wetting | <input type="checkbox"/> Car Accident |
| <input type="checkbox"/> Sports Injury | <input type="checkbox"/> Growing Pains | <input type="checkbox"/> other Pain |
| <input type="checkbox"/> Temper Tantrums | <input type="checkbox"/> Difficulty Sleeping | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Slow Physical Development | <input type="checkbox"/> Slow Mental Development | <input type="checkbox"/> Other _____ |

Please list any and all traumas or injuries child has experienced: _____

Has your child fell head first from a high place? _____

Please list & describe any surgeries your child has had: _____

Number of medications or Antibiotics child has taken in the past year: _____ Lifetime: _____

Please name any and all medications child is taking right now including OTC: _____

Please describe child's normal diet on a daily basis: _____

Does your child do any physical activity? Please describe what type & how often: _____

Prenatal & Birth History:

Complications during pregnancy? Y N if yes, please describe: _____

Ultrasounds during pregnancy? Y N if yes, how many & during which month? _____

Any medications taken before or during delivery? _____

Alcohol/Cigarettes/Drugs during pregnancy? Y N Was your baby full-term? _____

Circle Location of Birth: Hospital Home Birthing Center How long was the labor? _____

Interventions: Epidural? Y N Forceps? Y N Vacuum Extraction? Y N

VBAC? Y N C-Section? Y N If yes, emergency or planned? _____

Any complications with delivery? _____

Has child had vaccines? Y N Was there any adverse reaction? Y N _____

Authorization of Chiropractic Care for a Minor

I hereby authorize Dr. Van Veldhuizen at Van Family Chiropractic to administer care to my Son/Daughter as she deems necessary. I clearly understand and agree and I am personally responsible for payment of all fees charged by this office.

Signature of Parent or Legal Guardian _____

Date _____

Metabolic Assessment Form

Name: _____ Age: _____ Sex: _____ Date: _____

Please list the 5 major health concerns in your order of importance:

1. _____
2. _____
3. _____
4. _____
5. _____

Please circle the appropriate number "0 - 3" on all questions below. 0 as the least/never to 3 as the most/always.

Category I			
Feeling that bowels do not empty completely	0	1	2 3
Lower abdominal pain relief by passing stool or gas	0	1	2 3
Alternating constipation and diarrhea	0	1	2 3
Diarrhea	0	1	2 3
Constipation	0	1	2 3
Hard, dry, or small stool	0	1	2 3
Coated tongue of "fuzzy" debris on tongue	0	1	2 3
Pass large amount of foul smelling gas	0	1	2 3
More than 3 bowel movements daily	0	1	2 3
Use laxatives frequently	0	1	2 3
Category II			
Excessive belching, burping, or bloating	0	1	2 3
Gas immediately following a meal	0	1	2 3
Offensive breath	0	1	2 3
Difficult bowel movements	0	1	2 3
Sense of fullness during and after meals	0	1	2 3
Difficulty digesting fruits and vegetables; undigested foods found in stools	0	1	2 3
Category III			
Stomach pain, burning, or aching 1-4 hours after eating	0	1	2 3
Use antacids	0	1	2 3
Feel hungry an hour or two after eating	0	1	2 3
Heartburn when lying down or bending forward	0	1	2 3
Temporary relief from antacids, food, milk, carbonated beverages	0	1	2 3
Digestive problems subside with rest and relaxation	0	1	2 3
Heartburn due to spicy foods, chocolate, citrus, peppers, alcohol, and caffeine	0	1	2 3
Category IV			
Roughage and fiber cause constipation	0	1	2 3
Indigestion and fullness lasts 2-4 hours after eating	0	1	2 3
Pain, tenderness, soreness on left side under rib cage	0	1	2 3
Excessive passage of gas	0	1	2 3
Nausea and/or vomiting	0	1	2 3
Stool undigested, foul smelling, mucous-like, greasy, or poorly formed	0	1	2 3
Frequent urination	0	1	2 3
Increased thirst and appetite	0	1	2 3
Difficulty losing weight	0	1	2 3

Category V			
Greasy or high-fat foods cause distress	0	1	2 3
Lower bowel gas and or bloating several hours after eating	0	1	2 3
Bitter metallic taste in mouth, especially in the morning	0	1	2 3
Unexplained itchy skin	0	1	2 3
Yellowish cast to eyes	0	1	2 3
Stool color alternates from clay colored to normal brown	0	1	2 3
Reddened skin, especially palms	0	1	2 3
Dry or flaky skin and/or hair	0	1	2 3
History of gallbladder attacks or stones	0	1	2 3
Have you had your gallbladder removed	Yes	No	
Category VI			
Crave sweets during the day	0	1	2 3
Irritable if meals are missed	0	1	2 3
Depend on coffee to keep yourself going or started	0	1	2 3
Get lightheaded if meals are missed	0	1	2 3
Eating relieves fatigue	0	1	2 3
Feel shaky, jittery, or have tremors	0	1	2 3
Agitated, easily upset, nervous	0	1	2 3
Poor memory/forgetful	0	1	2 3
Blurred vision	0	1	2 3
Category VII			
Fatigue after meals	0	1	2 3
Crave sweets during the day	0	1	2 3
Eating sweets does not relieve cravings for sugar	0	1	2 3
Must have sweets after meals	0	1	2 3
Waist girth is equal or larger than hip girth	0	1	2 3
Frequent urination	0	1	2 3
Increased thirst and appetite	0	1	2 3
Difficulty losing weight	0	1	2 3
Category VIII			
Cannot stay asleep	0	1	2 3
Crave salt	0	1	2 3
Slow starter in the morning	0	1	2 3
Afternoon fatigue	0	1	2 3
Dizziness when standing up quickly	0	1	2 3
Afternoon headaches	0	1	2 3
Headaches with exertion or stress	0	1	2 3
Weak nails	0	1	2 3

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Symptom groups listed in this flyer are not intended to be used as a diagnosis of any disease condition.
For nutritional purposes only.

Category IX				
Cannot fall asleep	0	1	2	3
Perspire easily	0	1	2	3
Under high amounts of stress	0	1	2	3
Weight gain when under stress	0	1	2	3
Wake up tired even after 6 or more hours of sleep	0	1	2	3
Excessive perspiration or perspiration with little or no activity	0	1	2	3
Category X				
Tired, sluggish	0	1	2	3
Feel cold – hands, feet, all over	0	1	2	3
Require excessive amounts of sleep to function properly	0	1	2	3
Increase in weight gain even with low-calorie diet	0	1	2	3
Gain weight easily	0	1	2	3
Difficult, infrequent bowel movements	0	1	2	3
Depression, lack of motivation	0	1	2	3
Morning headaches that wear off as the day progresses	0	1	2	3
Outer third of eyebrow thins	0	1	2	3
Thinning of hair on scalp, face, or genitals or excessive falling hair	0	1	2	3
Dryness of skin and/or scalp	0	1	2	3
Mental sluggishness	0	1	2	3
Category XI				
Heart palpitations	0	1	2	3
Inward trembling	0	1	2	3
Increased pulse even at rest	0	1	2	3
Nervous and emotional	0	1	2	3
Insomnia	0	1	2	3
Night sweats	0	1	2	3
Difficulty gaining weight	0	1	2	3
Category XII				
Diminished sex drive	0	1	2	3
Menstrual disorders or lack of menstruation	0	1	2	3
Increased ability to eat sugars without symptoms	0	1	2	3
Category XIII				
Increased sex drive	0	1	2	3
Tolerance to sugars reduced	0	1	2	3
“Splitting” type headaches	0	1	2	3

Category XIV (Males only)				
Urination difficulty or dribbling	0	1	2	3
Frequent urination	0	1	2	3
Pain inside of legs or heels	0	1	2	3
Feeling of incomplete bowel evacuation	0	1	2	3
Leg nervousness at night	0	1	2	3
Category XV (Males only)				
Decrease in libido	0	1	2	3
Decrease in spontaneous morning erections	0	1	2	3
Decrease in fullness of erections	0	1	2	3
Difficulty in maintain morning erections	0	1	2	3
Spells of mental fatigue	0	1	2	3
Inability to concentrate	0	1	2	3
Episodes of depression	0	1	2	3
Muscle soreness	0	1	2	3
Decrease in physical stamina	0	1	2	3
Unexplained weight gain	0	1	2	3
Increase in fat distribution around chest and hips	0	1	2	3
Sweating attacks	0	1	2	3
More emotional than in the past	0	1	2	3
Category XVI (Menstruating Females Only)				
Are you perimenopausal	Yes	No		
Alternating menstrual cycle lengths	Yes	No		
Extended menstrual cycle, greater than 32 days	Yes	No		
Shortened menses, less than every 24 days	Yes	No		
Pain and cramping during periods	0	1	2	3
Scanty blood flow	0	1	2	3
Heavy blood flow	0	1	2	3
Breast pain and swelling during menses	0	1	2	3
Pelvic pain during menses	0	1	2	3
Irritable and depressed during menses	0	1	2	3
Acne breakouts	0	1	2	3
Facial hair growth	0	1	2	3
Hair loss/thinning	0	1	2	3
Category XVII (Menopausal Females Only)				
How many years have you been menopausal?				
Since menopause, do you ever have uterine bleeding?	Yes	No		
Hot flashes	0	1	2	3
Mental fogginess	0	1	2	3
Disinterest in sex	0	1	2	3
Mood swings	0	1	2	3
Depression	0	1	2	3
Painful intercourse	0	1	2	3
Shrinking breasts	0	1	2	3
Facial hair growth	0	1	2	3
Acne	0	1	2	3
Increased vaginal pain, dryness or itching	0	1	2	3

How many alcoholic beverages do you consume per week? _____

How many times do you eat out per week? _____

How many times a week do you eat fish? _____

List the three worst foods you eat during the average week: _____

List the three healthiest foods you eat during the average week: _____

Do you smoke? _____ If yes, how many times a day: _____

Rate your stress levels on a scale of 1-10 during the average week: _____

Please list any medications you currently take and for what conditions:

Please list any natural supplements you currently take and for what conditions:

Terms of Acceptance

When a patient seeks chiropractic care and we accept a patient for such care, it is essential for both to be working for the same objective.

Chiropractic has only one goal. It is important that each patient understands both the objective and the method that which will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: The adjustment is the specific application of forces to facilitate the body's correction of a vertebral subluxation. Our Chiropractic method of correction is by specific adjustments to the spine.

Health: The state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer the diagnosis or treatment of any disease. We only offer to diagnose either vertebral subluxation complex and/or neuro-musculoskeletal conditions. However, if during the course of a chiropractic spinal examination we encounter unusual finding which are outside the scope of practice for a Doctor of Chiropractic, we will advise you. If you desire advice, diagnosis, or treatment for those findings, we will recommend that you seek the services of another health care provider.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatments prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate major interference to the expression of the body's innate wisdom. Our only method is the specific adjustment to correct vertebral subluxation. However, we may use other procedures to help your body hold those adjustments.

I, _____ have read and fully understand the above statements.
(print name)

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. Therefore, I accept chiropractic care on this basis.

(signature)

(date)

Consent to evaluate and adjust a minor child

I, _____ being the parent or legal guardian of _____

Have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

For all Female Patients of Child-Bearing capability:

Pregnancy Release

This is to certify that to the best of my knowledge I am NOT pregnant and Dr. Van Veldhuizen has my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Date of last menstrual cycle: _____

(signature)

(date)

What aspects of Wellness do you want for yourself? (please check as many as you'd like)

- | | | |
|--|---|---|
| <input type="checkbox"/> More Energy | <input type="checkbox"/> Better Sleep | <input type="checkbox"/> Freedom from pain |
| <input type="checkbox"/> Better Concentration | <input type="checkbox"/> Enhanced emotional Well-being | <input type="checkbox"/> Reduce/Eliminate Medication use |
| <input type="checkbox"/> Improved Digestion | <input type="checkbox"/> Improved strength And endurance | <input type="checkbox"/> Greater resistance to Disease |
| <input type="checkbox"/> Easier breathing, Deeper breaths | <input type="checkbox"/> Better sports performance | <input type="checkbox"/> Better reaction time/reflexes |
| <input type="checkbox"/> Better Balance | <input type="checkbox"/> Improved Posture | <input type="checkbox"/> Overall Health Improvement |
| <input type="checkbox"/> Increased zest for Living | | |

Wellness goals for your family:
