BODY OF LIGHT FAMILY CHIROPRACTIC
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Congratulations on the birth of your child! We know and affirm that your child is perfect and complete. We are so honored and blessed that you are allowing us the privilege to be of service to your new family at this precious time. Please know that we will care for your children with the greatest respect and tenderness.

NEWBORN HISTORY

Birth to 2 months

Child's Name_____Birthdate_____ Sex:_____

Address_____City_____Zip_____

Parents' Names_____

Parent's Phone_____Work#_____

Parent's Employer_____

Siblings:_____

Whom may we thank for referring you to our office? _____

CAUSE

The human body is designed to be healthy. The primary system in the body that coordinates health is the nervous system. The healthy function of every cell, every system and every organ is dependent upon the integrity of the nervous system. The bones of the skull and vertebrae of the spine house and protect the central nervous system.

From the birth process until the present, events have occurred in your child's life that may have caused interference and damage to this delicate system. Physical, emotional and chemical stresses common to our contemporary lifestyles can result in misalignment and damage to the spinal column. This interference is called the Vertebral Subluxation Complex (VSC).

This form will help reveal the causes of Vertebral Subluxation that interfere with the optimal function of your child's nervous system and therefore impair your child's inborn health and well-being.

REASON FOR TODAY'S VISIT: _____

Does your child appear to be in pain or discomfort? Yes No If yes, when did this occur? _____

Was the onset: ____ Sudden ____ Gradual Is the problem: ____ Constant ____ Intermittent

Has your child ever had this problem before? Yes No _____

Has your child previously been treated for this problem? Yes No By whom? _____

Has your child previously had chiropractic care? Yes No By whom? _____

BIRTH HISTORY

LABOR AND DELIVERY

How long was the labor from the first regular contractions to the birth? _____ hours

How long was the 2nd stage (the pushing phase) of the labor? _____ hours

Hospital birth	Yes	No	_____
Home birth	Yes	No	_____
Midwife Assisted	Yes	No	_____
Vaginal Delivery	Yes	No	_____
Planned C-section	Yes	No	_____
Emergency C-section	Yes	No	_____
Was birth induced	Yes	No	_____
Forceps delivery	Yes	No	_____
Vacuum extraction	Yes	No	_____
Anesthesia administered	Yes	No	_____
Fetal Distress	Yes	No	_____
Meconium staining	Yes	No	_____
Head presentation	Yes	No	_____
Face presentation	Yes	No	_____
Breech presentation	Yes	No	_____

BABY'S CONDITION IMMEDIATELY AFTER BIRTH (answer to the best of your ability)**:**

Apgar Scores: At 1 minute _____/ 10 At 5 minutes _____/ 10 Unknown

Birth weight _____ lbs/kgs Birth Length _____ ins/cms Baby home on day _____

Baby's Crying: _____ Cried immediately after birth _____Weak Cry
_____ Cried strongly Did not cry for _____ minutes

Baby's Color: _____ Pink all over _____ Blue face _____ Blue hands/feet

Baby's Activity: _____ Arms and legs actively moving _____ Floppy baby

Was the baby put in intensive care? Yes No If yes, what was the reason and how long were they in for? _____
Was any medication given at birth? _____

Did you choose to vaccinate your child? Yes No If "Yes", check all the child has received.
___ DPT ___MMR ___Chicken Pox ___Hepatitis
Other:_____

Describe any and all reactions to vaccine(s).
_____

The power that made the body heals the body.

BABY'S CURRENT HEALTH STATUS:

How many hours does your baby sleep between feeds?		During day _____ At night _____
Does your baby go to sleep easily?	Yes	No _____
Does baby have a preferred sleeping position?	Yes	No _____
Does baby cry if you change this sleeping position?	Yes	No _____
Does baby have any feeding difficulties?	Yes	No _____
Is baby being breast-fed?	Yes	No If no, how long was baby breast-fed _____ wks/months
Does baby have a one sided breast preference?	Yes	No Preferred breast: Left / Right
Is baby formula fed?	Yes	No Which formula or other milk source? _____
Does baby frequently spit-up after feeding?	Yes	No _____
Does your baby cry a lot?	Yes	No For how many hours each day? _____
Does baby pass a lot of intestinal gas?	Yes	No _____
Does baby have a preferred head position?	Yes	No _____
Does baby frequently arch his/her head and neck backwards?	Yes	No _____
Does baby cry or become irritable during a diaper change?	Yes	No _____
Has baby ever had a fever?	Yes	No _____
Has baby had any falls?	Yes	No _____
Has baby been in a car accident or near miss?	Yes	No _____
Has baby had any other trauma?	Yes	No _____
Do you have any other concerns you wish to discuss?	Yes	No _____

CORRECTION

Today, we are becoming more aware how current technological lifestyles and practices expose our children's nervous systems to continuous stresses. These result in Vertebral Subluxations.

Current scientific research is showing the direct relationship between the function of the nervous system and the immune system. The integrity of the nerve system is therefore imperative to a healthy immune system in your growing child.

Today, your child has the opportunity to have a spinal analysis by a Doctor of Chiropractic, the only health care provider qualified to locate, analyze and correct the Vertebral Subluxation Complex. Correction of the Subluxation with the Chiropractic Adjustment is the beginning of greater health and well-being for your child.

AUTHORIZATION TO BILL INSURANCE/FINANCIAL POLICIES:

I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I agree that I am responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand that if I suspend or terminate my care, any fees for professional services rendered me will become immediately due and payable. I hereby authorize assignment of my insurance rights and benefits (if applicable) directly to the provider for services rendered. I also understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself.

AUTHORIZATION TO EXAMINE/PROVIDE CARE TO A MINOR:

I hereby Authorize Drs. Spear to perform a chiropractic evaluation, and provide chiropractic care if needed, to my child.

I also acknowledge that I have read through and agree to the financial policies and publishing of photographs/testimonials as described above.

Parent/Guardian: _____ _____

Print name Signature

Child's name: _____ _____

Date

Thank you for choosing Body of Light Family Chiropractic.
We know there is no more precious gift than your children.