

Kids A Brilliant ^ Life History

Name: _____ Address _____

Date: _____

Phone: _____ Date of birth _____

Emergency contact: _____ Phone _____

Legal guardian(s)

Name _____ Relation: _____

Address: _____

Phone: _____

Name _____ Relation: _____

Address: _____

Phone: _____

In your understanding, what does a chiropractor do? _____

Have you ever had your spine professionally examined? YES or NO

If yes, when: _____

Have you ever received adjustments by a doctor of chiropractic? YES or NO

If yes, when was your last visit? _____

For how long were you receiving chiropractic adjustments? _____

How often did you go to the chiropractor? _____

If you stopped, why? _____

Were you pleased with his/her service? _____

Does your immediate family receive chiropractic care? _____

Your Birth Forces

1. My mom perceived the pregnancy as: enjoyable easy moderate difficult very difficult ?
2. During the pregnancy, did your mother have any: falls accidents physical injuries ?
3. Prior to or during the pregnancy was your mother exposed to: (Circle all that apply)
 oral contraceptives meds for any condition tobacco petroleum
 fertility drugs strong cleaning agents alcohol other
4. Was your birth: (Circle all that apply)
 natural (no chemicals and vaginal delivery) cord around neck epidural prolonged labor
 chemically induced with Pitocin forceps or suction C-sect breech
 My birth was perceived by my mother as: enjoyable easy moderate difficult very difficult ?
5. During delivery your mother was: conscious semiconscious unconscious ?
6. My birth was: at home in birthing center hospital other
7. Were you: (Circle all that apply)
 incubated hospitalized circumcised nursed formula bottle-fed mother's milk

Falls

Circle all that apply and explain with dates (or ages):

out of crib _____ off ladder _____ on ice _____ roller-skates/blades _____

out of tree _____ off step _____ off bicycle _____ others _____

Accidents

Have you (even if you believe your injuries were minimal) been involved in a vehicular collision, or near collision? Please list dates, details or damage done to vehicle and you, rate severity (mild, moderate, or extreme). _____

Interventions (hospitalizations, transfusions, vaccinations, chemotherapy, etc.)

Explain with dates _____

Is the air that you live in clear of molds, dusts, new carpet fumes, etc? _____

Nutrition

How often do you consume the following?

caffeinated beverages _____ diet soda _____ sugar _____ chocolate _____

artificial sweeteners _____ junk food(flavored chips, dip, etc.) _____

Briefly describe your eating habits. (vegetarian, carnivore, some veggies, all fast food, etc)

How often do you laugh (really laugh)? _____

How often do you cry? _____

How often do you pretend? _____

How often do you play with others? _____

Consent for Children

I _____ as parent or legal guardian of _____ give consent

for Dr. Storti, or an approved substitute to provide Chiropractic services for my child or

ward.

Signatures:

Parent or guardian

Today's Date

Witness

Today's Date