All About YOU Profile

Please bring this completed health profile with you to the first visit. It will give me an opportunity to better understand factors affecting symptoms, and how I analyze and adjust the spine. At our first visit, Parent(s) and I will go over this form together and discuss any additional questions that may arise from comments noted here.

Thank you and I look forward to meeting you and your child!

Dr. Jenny Dubisar

_____
Today's Date

_____ _____
First Name Last Name

Age: _____ Birth Date: _____ Sex: M F

_____
Address City/State/Zip

Parent/Guardian Information

Are both Parents/Guardians in agreement with chiropractic care for this child: ❑ Yes ❑ No

Are there other siblings? ❒ Yes ❒ No
If yes, what are their names and ages? _____

(If either parent has a different last name/address/phone from the child, please provide that as well)

Parent Name: _____ Spouse/Parent Name: _____

_____ _____

Email: _____ Email: _____

(Please check your preferred contact number) (Please check your preferred contact number)

❒ Home Phone: (_____)_____ ❒ Home Phone: _____(___)_____

❒ Work phone: (___)_____ ❒ Work Phone: _____(___)_____

❒ Cell Phone: (___)_____ ❒ Cell Phone: (___)_____
❒ May I text you? ❒ May I text you?

Does the immediate family receive regular chiropractic care? ❑ Yes ❑ No

How did you discover this office and the professional services offered?_____

_____

What do you know about what we do? _____

_____

In case of Emergency Contact (other than a parent): _____

Relationship to Child: _____

Phone Contact number: _____

Is there a current concern or reason for seeking care? ❑ Yes ❑ No If yes, please share: _____

_____

_____

_____

Has Child seen another care provider for this concern? ❑ Yes ❑ No _____
IBCLC? ENT? Pediatrician? Specialist? Other? Name: _____
When did this situation begin? _____

Has Child ever experienced this health challenge previously? _____

_____

If applicable, please grade the level of significance of this health concern on the following abilities. Please use the following scale of 1-4; 1 being a mild affect, and 4 is a significant effect.

Affect on Play	❍ None or N/A	❍ 1	❍ 2	❍ 3	❍ 4
Affect on Exercise/Movement	❍ None or N/A	❍ 1	❍ 2	❍ 3	❍ 4
Affect on Social Life	❍ None or N/A	❍ 1	❍ 2	❍ 3	❍ 4
Affect on Walking	❍ None or N/A	❍ 1	❍ 2	❍ 3	❍ 4
Affect on Eating	❍ None or N/A	❍ 1	❍ 2	❍ 3	❍ 4
Affect on Rest/Sleep	❍ None or N/A	❍ 1	❍ 2	❍ 3	❍ 4
Affect on Sitting	❍ None or N/A	❍ 1	❍ 2	❍ 3	❍ 4
Affect on Overall Concern about Health	❍ None or N/A	❍ 1	❍ 2	❍ 3	❍ 4
Awareness of Concern During the Day	❍ None or N/A	❍ 1	❍ 2	❍ 3	❍ 4
Awareness of Concern During the Night	❍ None or N/A	❍ 1	❍ 2	❍ 3	❍ 4

Have any of your other family members ever had a similar health concern? _____

_____

There are 3 aspects to health: Physical, Chemical, and Emotional. When completing the next segment, please keep in mind that even minor stressors in these three primary areas add up to combine or to create interesting symptoms in the body.

Part 2: Health/Trauma/Medical/Healing History:

1. Has there been a significant injury or in any kind of vehicular accident(s)? ❒ Yes ❒ No
   a. If Yes, please explain: _____

   _____

1. Any significant trauma to the spine (Head, Neck, Back, Hips)? ❒ Yes ❒ No
   a) Date of most significant injury: _____
   b) What happened? _____

   _____
   c) Date of most recent injury: _____
   d) What happened? _____

   _____
2. In what position(s) does Child typically sleep? _____

3. Do you consult with a physician for anything OTHER than routine evaluations? ❒ Yes ❒ No
   a) If Yes, please explain: _____

4. Any nutritional supplements/Vitamins/herbs taken regularly?: _____

5. Any medications currently taking, or may have possibly taken over this past year, and please state the reason for taking them: _____

6. Any x-rays, Cat Scans, or MRI Images taken of the spine (Head, Neck, Back, or Hips)?
   ❒ Yes ❒ No
   Who/what/Where/Why _____

7. Does Child have all of their body parts? ❒ Yes ❒ No _____
8. Has Child had any surgeries? ❒ Yes ❒ No _____
9. Please list any bones that have broken/fractured, or any part severely strained/sprained: _____

Part 3: The Stress Survey

First, please rate the overall lifetime cumulative level of stress in each category from one to five, <u>one being minimal stress and five the highest level of stress</u>. Then, check all experiences that may apply to each category. In general, consideration of current stressors is going to be more relevant to the immediate care, although exposure to certain stressors during the developmental years needs to be taken into consideration for long-term stress adaptability.

1. Cumulative Physical Stress/Trauma

❍ 1 ❍ 2 ❍ 3 ❍ 4 ❍ 5

(Check those that apply):
- ❒ A difficult birth
- ❒ Accident/ injuries
- ❒ Sports activities
- ❒ Impacts
- ❒ Physical Trauma/Abuse
- ❒ Falls

2. Cumulative Chemical Stress:

❍ 1 ❍ 2 ❍ 3 ❍ 4 ❍ 5

(Check those that apply):
- ❒ Exposure to smoke
- ❒ Fumes
- ❒ Cigarette smoke
- ❒ Food additives
- ❒ Dehydration
- ❒ Medication(s)

3. Cumulative Emotional/Mental Stress:

❍ 1 ❍ 2 ❍ 3 ❍ 4 ❍ 5

(Check those that apply):
- ❒ Loss of loved ones
- ❒ Significant life changes
- ❒ Neuro-different
- ❒ Sexual Abuse
- ❒ Stress of being ill
- ❒ Move of home/school
- ❒ Separation/Divorce

Is there anything else which may help us better understand your child? _____

_____

_____

_____

Thank you for the opportunity to serve your child. I know your body already knows what it needs to do. Together, we can help you reach your optimal potential!

Warmly,

Dr. Jenny

A referral is the best compliment… if you appreciate the care you have received in our office, please share with others. If there is an issue to be addressed, constructive criticism along with potential solutions will be graciously received.

Please note the following policies and procedures in our office:

***Cancellation Policy**: Our policy is to request 24 hours notice of cancellation via voicemail, email or text message as this office is only able to serve clients through advance-scheduling. As a courtesy, we will text appointment reminders between 8am-10am on the day of your appointment. Any cancellation provided with less than a 3 hour notice may be subject to a $25 fee at the next appointment.*
Please sign here that you have read and understand our cancellation policy: _____

***Permissions Policy:** If this office is providing co-care for a client (for example, with a specific Pediatrician, Psychologist, Occupational Therapist, Acupuncturist, Massage Therapist or Other) we would like to have permission to share pertinent information relating to your care in this office. Please sign here if you give your permission for Dr. Jenny to share relevant information with your other health care provider(s):*

_____ (If you decline, please write 'Decline' with your initials)