SPINE TEAM CHIROPRACTIC

Dr. C. M. Lujan, DC, AT, CKTI

FIVE STANDARDS FOR NEW PATIENTS
➢ All new patients are required to fill out a personal health questionnaire.
➢ You will have a personal consultation with the doctor to discuss your intake form and health concerns &/or problems.
➢ Dr. Lujan will perform a diagnostic chiropractic, orthopedic, myotomes and neurological examination procedures.
➢ You will be advised if there is a need for additional procedures such as X-ray, MRI, or CT Scan.
➢ You will have a personal discussion with Dr. Lujan to discuss your care plan and treatment.

Patient Information			
Child's First Name:	**Middle Name:**	**Last Name:**	
Date of Birth: **Birth City/Town:**	**Sex:** ☐ **Male** ☐ **Female** **Birth State:**	**Age:**	
Address:	City:	State:	Zip Code:
Mother's Name:	Occupation:		
email:	Telephone:		
Father's Name:	Occupation:		
email:	Telephone:		
Reason for consulting our office:			
Is your infant under the care of another healthcare provider? If so, who?			
Who may we thank for referring you to our office?			

Consent for Chiropractic Care	
Being the parent / legal guardian of this child, I hereby authorize Dr. C. M. Lujan, DC AT CKTI and / or associates to evaluate and treat my son/daughter (name) ____ as they deem necessary.	
I also acknowledge and agree that I am financially responsible for any and all fees charged by this office and that payment will be made as services are provided.	
Parent / Guardian's Name (Print):	
Parent / Guardian's Name Signature:	
Date:	**Witnessed by:**

Heath Profile

Why is this information important?

As a family chiropractic office, we focus on your child's ability to be healthy. Our goals are first: to address the issues that brought you to this office, and second, to offer you and your child the opportunity of improved health potential and wellness services.

Addressing the issues that brought you to the office
If your child has no symptoms or complaints, and is here for wellness services please check ◻ here; Others need to briefly describe the chief area of complaint, including the effect it has on the child and any treatment tried to date for this complaint:
If he/she is experiencing pain, is it: ◻ Sharp ◻ Dull ◻ Comes & Goes ◻ Travels ◻ Constant
Since the problem started, is it: ◻ About the same ◻ Getting better ◻ Getting worse
What makes it worse:
What makes it better:
Does it interfere with: ◻ School ◻ Sleep ◻ Walking ◻ Sitting ◻ Hobbies ◻ Other:
Other Doctors seen for this problems: ◻ Chiropractor ◻ Medical Doctor ◻ Other:

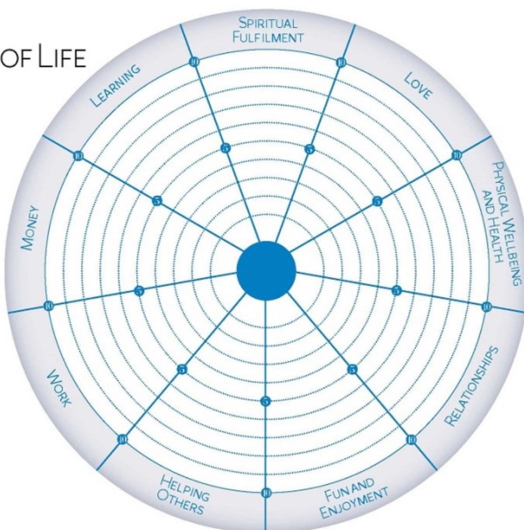
Check any of the following Conditions your child has suffered from during the past six months:			
◻ Ear Infections	◻ Scoliosis	◻ Seizures	◻ Chronis Colds
◻ Headaches	◻ Asthma/Allergies	◻ Digestive problems	◻ ADHD/ADD
◻ Recurring Fevers	◻ Growing/Back Pains	◻ Car Accident	◻ Bed Wetting
◻ Colic	◻ Temper Tantrums	◻ High fevers	◻ Head Injuries
◻ Repetitive Falls	◻ Serious Illness	◻ Epliepsy	◻ Meningitis
◻ Dizziness	◻ Diabetes	◻ Fainting	◻ Sinus Problems
◻ High Blood Pressure	◻ Heart Disease	◻ Constipation	◻ Diarrhea
◻ Rheumatic Fever	◻ Joint or Muscle Pain	◻ Neck pain	◻ Surgeries
◻ Hypoglycemia (low blood sugar	◻ Environmental Allergies	◻ Bladder Control Problems (enuresis)	
◻ Chemical sensitivities			
Has the child had prolonged use of medicines or an inhaler? ◻ No ◻ Yes, How long? _________________________			
Any Adverse reactions to any vaccinations (even if mild) Please explain: ______________________________________ ____			

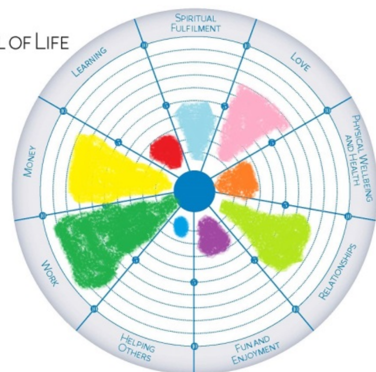
Daily we experience physical, chemical, and emotional stresses that can accumulate and result in serious loss of health potential. Most times, the effects are gradual and begin very early in life. Answering these questions will give us information that will allow us to better assess the challenges to your child's health potential.

Pregnancy History (Mother)		
Did you experience any of the following during your pregnancy? ***(If the child is adopted answer to the best of your ability)***		
□ Severe Viral Infection During 1st Trimester	□ Breech Position During Pregnancy	□ Diabetes
□ Accident or Infections	□ Severe Stress	□ Pre-Eclampsia
□ Alcohol Consumption or Drug Use	□ Radiation Exposure	□ Toxemia
□ Hypertension (High Blood Pressure)	□ Toxoplasmosis	□ Smoking
Where there any other complication to the pregnancy? □ No □ Yes, ____		
Was mom on any medications during pregnancy? □ No □ Yes, ____		
Was any antibiotics administered during labor and delivery time? □ No □ Yes, _______________________________		
Approximately how many ultrasounds were performed? ____		
Number of Pregnancies: ________ Number of Births: ________ Number of Miscarriages: _______ Number of Abortions: __________ Number of Living Children: _______		

Moms Eating Habits
□ Vegan Only □ Vegetarian Only □ Carnivore Only
□ Mixed: □ Veggies □ Red Meat □ White Meat □ Shellfish □ Fish □ Grains and Starches □ Dairy Foods □ Sweets
How many Home Cooked Meals do you cook daily ______ and weekly _______ Do you pack a lunch for work: □ Yes □ No
How much Take out do you eat daily ______ and weekly_______
How many? Glasses of Water do you drink daily ______ Cups of Coffee / Tea / Soda ______ Alcohol ______
My Exercise routine includes: □ Walking / Hiking □ Running / Jogging / Cycling / Swimming □ Weights □ Yoga / Palates □ I Don't Exercise Time& Duration of exercise: ________ minutes ______ weekly Exertion: □ Stroll □ Mild □ Moderate □ Heavy

Wheel of Life Balance: **Wellness is a balance of many factors. Using the circle, shade your level of satisfaction in each area as it relates to you. Start from the center pointing outwards.**





Newborn History			
☐ Required resuscitation / Oxygen	☐ Distorted Skull	☐ Prolonged Jaundice	
☐ Difficulty latching / Sucking	☐ Falls Asleep	☐ "Clicking" sounds	☐ Colic
Breast Fed: ☐ Yes ☐ No	How long? ________ Months _________ Years		
Formula Fed: ☐ Yes ☐ No	How long? ________ Months _________ Years		
Any food allergies or intolerance ☐ Yes ☐ No List:	Introduced to solids at ___________ Months old		
Birth Weight: ______ lbs. ______ oz. Birth Length: ________ in. APGAR Score: _______			
Baby Sleeps on: ☐ Tummy ☐ Back ☐ Side ☐ Sleeps with Mom ☐ Is A Poor Sleeper			
Sleeping Habits: Sleeps _____ hours at Nighttime Sleep ______ hours during daytime Takes _____ hour Naps			
Were any antibiotics / vaccination (i.e. Hepatitis B) administered immediately after birth? ☐ Yes ☐ No			
Current Medical Pediatrician: ___________________________________ Phone #: ___________________________			

Developmental History			
According to the National Safety Council approximately 50% of children fall head first from a high place during their 1st year of life (i.e. Bed, Changing table, stairs, etc.)			
Was this the case with your child?	☐ Yes	☐ No	When?
Has your child ever been in a car accident?	☐ Yes	☐ No	When?
Has your child had any childhood illnesses?	☐ Yes	☐ No	When?
Has your child had any surgeries	☐ Yes	☐ No	Describe
Does your child play any sports	☐ Yes	☐ No	Which Sport (s)?
Weight of School Back Pack? _______________ lbs.			
Average # of hours per week playing video games or watching TV? __________ games, _________ TV.			
What age did your child begin to crawl? __________ Months.			
What age did your child begin to walk UN-assisted?			
Does or Did your child have any of the following?			
☐ Difficulty with crawling (on all fours)	☐ Did not crawl on all fours		
☐ Difficulty learning to ride a bike	☐ Appears clumsy		
☐ Difficulty learning to read	☐ Difficulty with writing		
☐ Difficulty using utensils	☐ Difficulty buttoning clothing		
☐ Difficulty tying shoes	☐ Difficulty or awkward with walking / running		
☐ Poor hand-eye coordination	☐ Difficulty sitting still or paying attention		

Please describe your infant's personality
What is the emotional climate of your home?
Do your have any pets in your home? ☐ No ☐ Yes
Does anyone in the home smoke? ☐ No ☐ Yes

Neurological / Other	
Has your child ever been diagnosed by a medical professional with any of the following, if yes, by whom;	
□ Hearing Loss or Impairment	□ Visual Impairment
□ Neurological disorder	□ Anxiety / Depression / Bipolar
□ Obsessive Compulsive Disorder (OCD)	□ Autism / Autism Spectrum Disorder
□ ADD / ADHD	□ Tourette's Syndrome
□ Dyslexia	□ Other
Current / Past Medications and Treatment -	
List any medications that your child is taking: (name brand, dosage, frequency)	List any special dietary needs that your child has:
List any supplements that your child takes:	List any treatment that your child is currently undergoing with any health professional:
List any special services that your child is currently receiving at school or privately;	List any previous chiropractic treatment, medications, or other medical treatment that your child has undergone:

Please Read Carefully

The statements made on this form are accurate to the best of my recollection and I hereby authorize this office and its Doctors to administer medical care to my Son / Daughter as they deem necessary. I understand and agree that health and accident insurance policies are an arrangement between the insurance carrier and myself. I authorize payment from my insurance carrier directly to this office with the understanding that full or partial payments will be credited to this account upon receipt. I also acknowledge that not all chiropractic services are covered by my insurance carrier and any outstanding balances not covered by my insurance carrier, will be paid in full by the patient / guardian. However, I clearly understand and agree that all services rendered to my son / daughter will be immediately due and payable.

Parent's signature   Date