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Child's Name: _____ DOB: _____ Date: _____
Parent's/Guardian's Name: _____
Home Address: _____
Home Phone: _____ May we leave a message? Yes No
Parent's Cell Phone: _____ May we leave a message? Yes No
Parent's E-mail: _____
How did you hear about us? _____
Siblings and ages: _____
Previous Chiropractic Care? Yes No

Emergency Contact

Name: _____ Relationship to child: _____
Phone Number: _____ Alternative Phone Number: _____

Why have you decided to have your child evaluated by a Chiropractor?

- He/She is continuing care from another chiropractor.
- I recently had my spine checked and understand the value in getting my child checked.
- I have concerns about his/her health and I'm looking for answers.
- He/She has a specific condition and I've learned that chiropractic may be able to help.
- I want to improve my child's immune function.

Post Natal & Infant History

How many weeks gestation was the baby at birth? _____ Weight: _____ Length: _____
Was the baby ever admitted to the NICU? No Yes
If yes, for how long and why? _____
Was any medication given to the child at birth? No Yes Unsure
If yes, what medication any why? _____
Was your child exclusively breastfed? No Yes Months: _____
Was your child breastfed + formula fed? No Yes Months: _____
Did your child show any sensitivities to formula (reflux, eczema, arching back)? No Yes
Did you introduce cereal or grains within your child's first year? No Yes
Did your child spend a lot of time in any baby devices (bouncy seats, swings, bumbos, car seats, etc.?)
 No Yes Which ones? _____

Wellness Profile

The human body is designed to be healthy. The primary system in the body which coordinates health and function is the nervous system. Your nervous system is surrounded and protected by the bones of the spine, called **vertebrae**. Many of the common health challenges that adults experience have their origins during the **developmental years**, some starting at birth. Layers of damage to the spine and **nervous system** occur as a result of various **traumas, toxins, and emotional stress**. The result may be misalignment to the spinal column and damage to the nervous system – a condition called about your child’s state of wellness and factors which may be contributing to vertebral subluxation and impeding your child’s ability to heal.

What signals has your child’s body been communicating?

CURRENT	PREVIOUS		CURRENT	PREVIOUS		CURRENT	PREVIOUS	
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	Failure to Thrive/Slow Weight Gain
<input type="checkbox"/>	<input type="checkbox"/>	Respiratory Tract Infections	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>	Slow or Absent Refluxes
<input type="checkbox"/>	<input type="checkbox"/>	Sinus Problems	<input type="checkbox"/>	<input type="checkbox"/>	Flatulence	<input type="checkbox"/>	<input type="checkbox"/>	Asymmetrical Crawling or Gait
<input type="checkbox"/>	<input type="checkbox"/>	Ear Infections	<input type="checkbox"/>	<input type="checkbox"/>	Headaches/Migraines	<input type="checkbox"/>	<input type="checkbox"/>	Weight Challenges
<input type="checkbox"/>	<input type="checkbox"/>	Tonsillitis	<input type="checkbox"/>	<input type="checkbox"/>	Neck Pain	<input type="checkbox"/>	<input type="checkbox"/>	Bed Wetting
<input type="checkbox"/>	<input type="checkbox"/>	Strep Throat	<input type="checkbox"/>	<input type="checkbox"/>	Torticollis / Head Tilt	<input type="checkbox"/>	<input type="checkbox"/>	Sleep Problems
<input type="checkbox"/>	<input type="checkbox"/>	Frequent Colds / Croup	<input type="checkbox"/>	<input type="checkbox"/>	Trouble Feeding on One Side	<input type="checkbox"/>	<input type="checkbox"/>	Night Terrors
<input type="checkbox"/>	<input type="checkbox"/>	Recurrent Fevers	<input type="checkbox"/>	<input type="checkbox"/>	Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	Tip Toe Walking
<input type="checkbox"/>	<input type="checkbox"/>	Eczema	<input type="checkbox"/>	<input type="checkbox"/>	Growing Pains	<input type="checkbox"/>	<input type="checkbox"/>	Sensory Processing Issues
<input type="checkbox"/>	<input type="checkbox"/>	Rashes	<input type="checkbox"/>	<input type="checkbox"/>	Scoliosis	<input type="checkbox"/>	<input type="checkbox"/>	Seizures
<input type="checkbox"/>	<input type="checkbox"/>	Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Red, Swollen, Painful Joint	<input type="checkbox"/>	<input type="checkbox"/>	Tremors / Shaking
<input type="checkbox"/>	<input type="checkbox"/>	Food Sensitivities	<input type="checkbox"/>	<input type="checkbox"/>	Colic	<input type="checkbox"/>	<input type="checkbox"/>	ADD / ADHD
<input type="checkbox"/>	<input type="checkbox"/>	Digestive Problems	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Crying Spells	<input type="checkbox"/>	<input type="checkbox"/>	Autism / PPD

Do you have a specific concern that brings you in?

No, I would like my child’s nervous system assessed to achieve optimal health & functioning.

Yes: _____

If yes, please answer the following questions:

Does your child appear to be in pain in discomfort? _____ For how long? _____

Is it getting better, worse, or staying the same? _____ Suddenly or gradually? _____

Have you seen other health professionals regarding this complaint?

No if Yes, Whom?

What treatment did they use? _____

Has your child taken any medication for this complaint? No Yes:

Has your child ever experienced this complaint before? No Yes:

Has your child had x-rays in relation to the current complaint? No Yes:

Has your child had any blood work done for the current complaint? No Yes:

Birth Experience

- Location of Birth: Home Hospital Birthing Center Other: _____
- Birth Attendants: Doula Midwife GP OB Other: _____
- Medications during labor/delivery including IV antibiotics: No Yes
- Was Pitocin used to induce/speed up labor? No Yes
- Were your membranes ruptured by a medical professional? No Yes
- Was your child at any time during pregnancy in a constrained position? No Yes Unsure
- If yes, please describe: Breech Transverse Face / Brow presentation
- Was your delivery vaginal or C-section? _____ If C-section, was it planned or emergency? _____
- If it was vaginal, was the baby presented: Head Face Breech
- Were any of the following interventions used? Forceps Vacuum Extraction Other
- Were there any complications during delivery? No Yes
- If yes, please specify: _____
- How long was the labor from the first regular contractions to the birth? _____ hours
- How long was the second stage (the pushing phase) of the labor? _____ hours
- Was the baby born with any purple markings / bruising on their face or head? No Yes
- Any concerns about misshapen head at birth? No Yes

Physical Traumas

- Has your child ever fallen from any high places? No Yes _____
- Has your child ever been involved in a motor vehicle accident? No Yes _____
- Has your child broken any bones? No Yes _____
- Has your child had any previous hospitalizations? No Yes _____
- Has your child had any previous surgeries? No Yes _____
- Does your child use a tablet, computer, or video game? Never Rarely Daily Several hrs/day
- Does your child watch TV? Never Rarely Daily Several hrs/day
- Does your child exercise? No Daily Weekly Seasonally
- Does your child play contact sports? No Daily Weekly Seasonally
- Does your child sleep on their... Back Belly Sides (both, right, left)
- Does your child carry a back pack? No Yes
- Does it weigh less than 15% of their body weight? No Yes
- Do they wear their back pack on 2 shoulders? No Yes
- Do your child's shoes show excessive or uneven wearing out? No Yes
- Does your child wear custom orthotics?
No Yes, for what purpose? _____

Goals & Consent

Do you feel your child is developmentally appropriate for their age?

Intellectually:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Emotionally:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Physically:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____

What is your primary goal for your child at our office? _____

Our goals are to provide a detailed assessment of your child’s current status and provide to you the resources for a highly engaged and healthy child whose body is functioning at its absolute peak potential while they grow. Essential to this healthy growth is a nervous system functioning free from interference called subluxations. You’ve taken an important step for your child’s future through a chiropractic evaluation!

Consent to Evaluation of a Minor Child

I, _____, being the parent or legal guardian of _____
(print name of consenting adult) *(print name of minor)*

Hereby grant permission for my child to receive a chiropractic evaluation including history, spinal scan, and physical examination. Any findings will be communicated before consenting to commencement of treatment, if appropriate.

Consenting Adult’s Signature

Date