

## VERTEBRAL SUBLUXATION ASSESSMENT

1. Has your child been checked by a Doctor of Chiropractic? YES - NO  
Name of Chiropractor? \_\_\_\_\_  
Were X-rays taken? YES - NO  
Who is your regular Pediatrician? \_\_\_\_\_
  
2. Did you have ultrasound during this pregnancy? YES - NO  
How frequently? \_\_\_\_\_  
\* Place of birth: Home Birthing Center Hospital  
\* Provider: Midwife OB-GYN Other \_\_\_\_\_  
\* Type of birth Vaginal C-Section Was anesthesia used? YES - NO Type \_\_\_\_\_  
\* Was Labor induced? YES - NO If yes, why? \_\_\_\_\_  
\* What position did you deliver in? Squatting On back  
\* Birth Trauma: Doctor assisted Twisting / pulling Vacuum Extraction Forceps  
\* Newborn Trauma: (medical procedures and tests) \_\_\_\_\_
  
3. Did you breast-feed your child? YES - NO How long? \_\_\_\_\_  
Was your decision supported by your health care provider? YES - NO  
Repeated studies are now informing us breast-feeding develops strong and healthy immune, neurological and digestive systems.
  
4. According to the National Safety Council approximately 50% of infants have fallen onto their heads during their first years of life. Another study reveals ¼ million children are injured in playgrounds annually.  
Can you recall any such jolts, falls or trauma to your child? YES - NO  
What happened? \_\_\_\_\_  
Any fractures or dislocations? YES - NO Where? \_\_\_\_\_
  
5. Which sports does your child play? \_\_\_\_\_
  
6. Other than the 5 hours per day spent sitting in the classroom, does your child spend additional prolonged time sitting? YES - NO  
Is it in front of the computer or T.V.? \_\_\_\_\_
  
7. How would you rate your child's diet? \_\_\_\_\_  
Does your child consume artificial sweeteners? YES - NO Fluoridated water? YES - NO
  
8. Check any of the following conditions your child has suffered from:  
Colic Irregular Sleeping Patterns Night Terrors Seizures Tantrums  
Ear Infections Allergies Asthma Headaches Poor Digestion  
Repeated Infections or Colds Bed Wetting Learning Difficulties  
Emotional Disorders ADD or ADHD Other \_\_\_\_\_
  
9. How often has your child been treated with drugs? \_\_\_\_\_  
Were you informed of their adverse reactions? YES - NO  
If it was an antibiotic, was your child cultured for its use? YES - NO  
Is your child currently on any medications? YES - NO Please list: \_\_\_\_\_
  
10. The Child's immune system, like all other developing systems of the body, is both intricate and delicate. It strives for a state of homeostasis and balance in the body. Long term adverse effects from interfering with this process with artificial immunizations are just being uncovered.  
Were you adequately informed of the risks of vaccinating your child? YES - NO  
Did your child experience any behavioral, emotional or physical changes within 3 months after any shots?  
YES - NO Describe: \_\_\_\_\_  
Was it reported by you or your doctor? YES - NO