

**Inspired Healing**  
Dr. Joanne Hauptert D.C.

**Child Health Profile**

**Date:** \_\_\_\_\_

First Name \_\_\_\_\_ Last Name \_\_\_\_\_

Address \_\_\_\_\_

Zip \_\_\_\_\_ Home Phone \_\_\_\_\_

Date of Birth \_\_\_\_\_

Referred by \_\_\_\_\_

Parents e-mail address \_\_\_\_\_

Do you currently have any health concerns?  Yes  No

Please describe: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What methods have you tried to address these concerns? \_\_\_\_\_  
\_\_\_\_\_

What do you hope to receive from Network care in this office? \_\_\_\_\_  
\_\_\_\_\_

Does your immediate family receive Network care?  Yes  No

There are many types of stress that affect the health of your body and nervous system; these stresses may be **physical, chemical, or emotional**.

**Birth Stress:**

Was your birth difficult or traumatic?  Yes  No

Did your mother have an illness or injury before or during pregnancy?  
 Yes  No

Was your birth:  drug induced  C- section  forceps or suction  
 breech  prolonged  cord around neck  
 other \_\_\_\_\_

**Emotional Birth Stress**

Was your birth:  at home  in a birthing center  hospital  
 other

Were you incubated or isolated after birth?  Yes  No

## Inspired Healing

### Birth and Early Childhood/Chemical Stress

Before or during her pregnancy with you, did your mother regularly:

smoke     drink alcohol     take drugs or medications

During labor and delivery, was your mother:  conscious

semi-conscious     unconscious

Were you fed:  formula     bottle fed     mother's milk

nursed

List any childhood illnesses or medications: \_\_\_\_\_

\_\_\_\_\_

### Vehicular Accidents

Have you been in a vehicular accident? (Even if you don't think you were hurt)

Yes     No

Please describe. Give approximate dates, severity, and vehicle involved.

(car, bike, etc.) \_\_\_\_\_

\_\_\_\_\_

### General Physical Stress

Falls? \_\_\_\_\_

Sports impacts? \_\_\_\_\_

Physical fights? \_\_\_\_\_

Knocked unconscious? \_\_\_\_\_

Broken bones? \_\_\_\_\_

Sprains/strains? \_\_\_\_\_

Used crutches, cane or walker? \_\_\_\_\_

During the day, do you mostly:

sit     walk     do desk work     do phone work     stand     drive

read at computer     do heavy lifting

Are there any habitual postures or positions you remain in for prolonged periods?

Ex: reading, watching T.V., playing a musical instrument

Yes     No    If yes, why? \_\_\_\_\_

\_\_\_\_\_

List any surgeries: \_\_\_\_\_

\_\_\_\_\_

Do you have all your body parts?  Yes     No \_\_\_\_\_

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### General Chemical Stress

Are you taking any drug (**prescription or over-the-counter**) regularly?

Yes  No

List drug(s), how long you have been taking them, and reason for taking them:

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Are they prescribed by a physician?  Yes  No, last visit \_\_\_\_\_

Do you or did you work with any chemical, fume, dust, powder, smoke, etc. for prolonged periods?  No  Yes, describe \_\_\_\_\_

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Check any of the following that you consume, and give frequency (ex: daily, 3x/wk, weekly, etc.):

alcohol \_\_\_\_\_ fruit \_\_\_\_\_ artificial sweeteners \_\_\_\_\_

soda \_\_\_\_\_ whole grains \_\_\_\_\_ coffee \_\_\_\_\_

cooked/canned vegetables \_\_\_\_\_ dairy \_\_\_\_\_

raw vegetables \_\_\_\_\_ tobacco \_\_\_\_\_ fried foods \_\_\_\_\_

refined sugars \_\_\_\_\_ meats \_\_\_\_\_ diet foods \_\_\_\_\_

organic foods \_\_\_\_\_

Do you think your diet enhances or stresses your body? \_\_\_\_\_

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### General Emotional Stress

Check any of the following that apply. **P** stands for **past**, **C** for **current**, leave blank if not applicable

	Mild	Moderate	Extreme		Mild	Moderate	Extreme
Childhood				Work Related			
School				Commuting			
Play/recreation				Loss of loved one			
Family				Change in life style			
Relationship				Change in vocation			
Illness				Abuse			

## Inspired Healing

Have you suffered from depression? No\_\_\_ Yes\_\_\_ Since\_\_\_\_\_

Do you get headaches more often than 2 times a month? Yes\_\_\_ No\_\_\_  
Since when\_\_\_\_\_

Do you have trouble with (please circle) bowel movements, indigestion, or gas?  
Since when\_\_\_\_\_

Do you get quality sleep? Yes\_\_\_ No\_\_\_  
Since when\_\_\_\_\_

Do you have less energy than you want? Yes\_\_\_ No\_\_\_  
Since when\_\_\_\_\_

Are there any particular factors or elements about your life that you feel impair  
your opportunity for full health?\_\_\_\_\_

\_\_\_\_\_

What brings joy and meaning to your life?\_\_\_\_\_

\_\_\_\_\_

What is your current strategy for coping with:  
*Stress?* \_\_\_\_\_

*Uncertainty?* \_\_\_\_\_

\_\_\_\_\_

Is there anything else you wish to share, which may help me to better understand  
you, your history, or you professional needs, that has not been discussed on this  
questionnaire?\_\_\_\_\_

\_\_\_\_\_

**Thank you for choosing Network Spinal Analysis and  
Inspired Healing. I look forward to helping you to  
develop a healthy spine and nervous system. I am  
excited about assisting you on your journey towards  
greater health and wellness.**