

# CHILD HEALTH PROFILE & PERMISSIONS

- to be completed by Parent



HEALTH, VITALITY AND COMMUNITY

**Initial Visit Date:** YY/MM/DD

**Name of Parent:** \_\_\_\_\_ **Name of Child:** \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Date of Child's Birth: YY/MM/DD Child's Age: \_\_\_\_\_ Gender: F M

**How did you hear about our office?** \_\_\_\_\_

**Has your child ever received Spinal Adjustments or Network Spinal Analysis Entrainments by a Doctor of Chiropractic before? YES NO**

If yes when and by whom? \_\_\_\_\_ How long did your child go? \_\_\_\_\_

Have you or your spouse ever received Chiropractic care? **YES NO** Network Care? **YES NO**

What other natural forms of healthcare has your child received? \_\_\_\_\_

**What do you hope for your child to receive from Chiropractic care in this office?**

\_\_\_\_\_  
\_\_\_\_\_

## PLEASE ANSWER THE FOLLOWING QUESTIONS ABOUT YOUR CHILD'S HEALTH HISTORY

Were you physically ill prior to or during the pregnancy? **YES NO** \_\_\_\_\_

Was the pregnancy difficult? **YES NO** \_\_\_\_\_

Did you have any falls, accidents or physical injuries during the pregnancy? **YES NO** \_\_\_\_\_

Was your labor chemically induced? **YES NO** \_\_\_\_\_



Were you conscious / semiconscious / unconscious? \_\_\_\_\_

Was the birth:  drug induced       forceps or suction       C-section       breech  
 natural       prolonged       cord around the neck

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

Was your child incubated or isolated? **YES NO**

Was your child:  bottle fed       breast fed       other \_\_\_\_\_

### HAS YOUR CHILD EXPERIENCED ANY OF THE FOLLOWING?

(If so please list when and any further comments you wish to share):

- |   |                                     |                                      |  |                                    |
|---|-------------------------------------|--------------------------------------|--|------------------------------------|
| <input type="radio"/> Headaches                   | <input type="radio"/> Allergies     | <input type="radio"/> Ear infections | <input type="radio"/> Breathing problems | <input type="radio"/> Fatigue      |
| <input type="radio"/> Irritability                | <input type="radio"/> Hyperactivity | <input type="radio"/> Flu            | <input type="radio"/> Frequent colds     | <input type="radio"/> Bloody noses |
| <input type="radio"/> Meningitis                  | <input type="radio"/> Diarrhea      | <input type="radio"/> Colic          | <input type="radio"/> Constipation       | <input type="radio"/> Rashes       |
| <input type="radio"/> Milk or lactose intolerance | <input type="radio"/> Bed Wetting   | <input type="radio"/> Asthma         | <input type="radio"/> Sleeping disorders |                                    |
| <input type="radio"/> Digestive problems          | <input type="radio"/> Other _____   |                                      |  |                                    |

### REGARDING YOUR CHILD TODAY:

Has your child ever been unconscious? **YES NO** \_\_\_\_\_

Has your child ever used crutches or corrective braces? **YES NO** \_\_\_\_\_

Is your child accident-prone? **YES NO** \_\_\_\_\_

Has your child had any falls down steps? **YES NO** \_\_\_\_\_

Has your child ever been involved in an auto accident? **YES NO** \_\_\_\_\_

Has your child ever been hospitalized or had surgery? **YES NO** \_\_\_\_\_

Has your child ever had any broken bones or sprain injuries? **YES NO** \_\_\_\_\_

Is your child currently on any medications? YES NO In the past? **YES NO** Please List Medications: \_\_\_\_\_

Has your child been vaccinated? **YES NO** \_\_\_\_\_

Is your child active in any particular sports? **YES NO** If yes which ones? \_\_\_\_\_



Is your child hyperactive? **YES NO**

Does your child have learning disorders? **YES NO**

Does your child have poor posture? **YES NO**

Is your child nervous, or has anyone suggested that your child was nervous? **YES NO**

How would you rate your child's physical health?

excellent     good     fair     poor     getting better     getting worse

How would you rate your child's emotional/mental health?

excellent     good     fair     poor     getting better     getting worse

Is there anything else you wish to share which may help us to better understand your child?

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**I hereby authorize Dr. Jasmine Therese Esguerra D.C., of the Pure Wellness Intl, and whomever she may designate, to administer care necessary to my child named above.**

Parent/Guardian's Name: \_\_\_\_\_

Parent/Guardian's Signature: \_\_\_\_\_ Witness: \_\_\_\_\_

Dated this \_\_\_\_\_ day of \_\_\_\_\_ 20\_\_\_\_\_



HEALTH, VITALITY AND COMMUNITY

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I hereby request and consent to receiving spinal care, including wellness education in this office by a chiropractor(s) who provides Network Spinal Analysis (NSA) Care, a low force approach which has unique outcomes and clinical results. This practitioner(s) chooses to practice NSA, as he/she is professionally and personally confident in regard to the safety and effectiveness of this form of care.

This office provides care in accordance with the Council on Chiropractic Practice Guidelines and the Canon of Ethics of the Association for Network Care, and my doctor(s) has been trained in traditional chiropractic care and certified in the procedures of Network Spinal Analysis Care.

The purpose of this consent form is to help me better understand the nature of the services offered in this office and our mutual responsibilities. This fosters a more effective relationship and avoids misunderstandings regarding expectations. Having well understood expectations is anticipated to promote a greater sense of safety and healing.

NSA does not attempt to manually, or by instrument, manipulate spinal fixations structurally (often associated with a snapping or popping sound), nor does it directly treat painful areas of the spine and body. **Instead, by enhancing my body's awareness of itself and specifically my spine, I understand I can develop new strategies for healing, adapting to stress, and experiencing wellness. These strategies promote spontaneous self-correction and self-regulation of spinal tension patterns and healing.**

NSA consists of gentle touch contacts along the neck and back to achieve greater communication between the brain and body, and new sensory and motor strategies. NSA adopts an approach associated with somatic (body/spinal awareness) training. There is a body of research characterizing NSA care and documenting its unique and significant wellness benefits. I understand I may obtain copies of published research articles and/or abstracts in this office.

I am aware that I will be receiving gentle touch Network adjustments, also called entrainments. Assessments of my progress will include monitoring of my spine and body awareness, responsiveness to inner rhythms, tension, and ease patterns. At regular intervals, following commencement of care, reassessment will be performed. These will include my personal perception of my wellness and my awareness of my spine and body-mind changes. My chiropractor(s) will report to me the improvement in my spinal and nervous system integrity and my ability to self-regulate tension and to reorganize my spine.

**NSA is advanced through a series of Levels of Care.** Each Level of Care involves the development of new and unique spontaneous spinal wave motions, other body movements, and oscillations. These waves, which are suggested to be associated with greater spinal stability, the redistribution of energy, and the transfer of internal information are also associated with greater wellness, improved quality of life, and increased life enjoyment.

I also understand that, in addition to NSA care and wellness education, my practitioner(s) may perform additional examinations or assessments and offer health/spinal care or advice that is consistent with my individual needs.

#### PLEASE READ AND SIGN THE FOLLOWING:

It has been explained to my satisfaction, and I understand that the care offered at this office is not a form of, or replacement for, the diagnosis or treatment of any symptom, disease, or malady. Instead, it is a form of wellness care and self-education that em-



powers my connection with my body-mind and develops new strategies for spinal and nervous system integrity and wellness. It develops new capacities in my body for the identification of, spontaneous release of, and redirection of tension, including those that are unique to NSA care.

It is common for people receiving NSA care to breathe more deeply and more fully, engaging the spine with their respiration, to spontaneously adapt postures that release or redistribute tension, to bust stress, and to experience more of their inner life energy. I understand it is common to experience a wider range of motion and emotion during care. It is common, as care progresses, to find new options in the body and in life, which often lead to significant life changes.

**This form of care is NOT suggested for those individuals who wish to remove a symptom or condition without the occurrence of other fundamental changes in their lives. The care in this office often promotes significant changes in health choices, lifestyle, experience of the body-mind, emotion, and consciousness.**

Rather than attempting to simply return me to my previous state minus a symptom, this chiropractor instead chooses to help me achieve new levels of wellness and life potential that I may never have had before.

Although in this office we seek to help you develop new strategies for wellness and spinal and nerve system integrity, as a chiropractor the sole condition of concern is that of the vertebral subluxation. Our insurance carrier requires that the following information be given to you and signed by you prior to commencing care.

In Network Care, we categorize these subluxations into two categories, a structural segmental distortion and a spinal cord/nerve elongation or stretching. Through the gentle force applications at the spine to enhance spinal and nerve system integrity, subluxations are corrected. This is the only condition that we address in our office.

The only condition we offer to diagnose and correct is the vertebral subluxation and loss of spinal and neural integrity in relationship to this. We do not offer to diagnose or treat any other condition, disease, or symptom. If during the course of our spinal assessment/examination we encounter non-chiropractic or unusual findings, we will advise you of this. If you desire advice on further diagnosis or treatment of this condition, situation or circumstance, we will recommend that you seek the services of another health care provider whose practice is geared towards such differential diagnosis and treatment.

**I have read, or have had read to me, the CONSENT TO RECEIVE NETWORK SPINAL ANALYSIS™ (NSA) CARE and understand that the care in this office is different from what many consumers may expect from chiropractors practicing manipulative therapy. I agree to receive care, which consists of or includes NSA care and wellness education. I understand that I am not passive in the process, that I am an active participant in my care and in my healing.**

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PRINTED NAME OF CHILD PRACTICE MEMBER

PRINTED NAME OF PARENT OR GUARDIAN

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SIGNATURE OF PARENT OR GUARDIAN

DATE

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PRINTED NAME OF WITNESS

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SIGNATURE OF WITNESS

DATE