Child Health Questionnaire (4 – 12 years)

Personal Information:

Date: ___________

Child's Name: ______________________________
Child's Address: ______________________________
City: ______________ State: ______ Zip: ________
Birth date: ____________ Age: ______ Gender: M F
Soc. Sec #: ________________ Grade Level: _____
Child's Home Phone No. (   ) ______________
Mother's Name: ______________________________
Mother's Cell Phone No. (   ) ______________
Mother's E-mail: ______________________________
Mother's Employer: ______________________________
Work Phone: (   ) ______________ Ext: ______
Father's Name: ______________________________
Father's Cell Phone No. (   ) ______________
Father's E-mail: ______________________________
Work Phone: (   ) ______________ Ext: ______
Number of Siblings: _____ Ages: ______________
Referred By: ______________________________
Interested in appointment reminders? O Email O Text

Insurance Information:

Do you expect insurance to contribute to your child's care? O Yes O No
Insured's Name: ______________________ DOB: ________
Relationship to Child: ______________ Effective Date: ________
Insurance Company: ______________________________
ID *or* Contract Number: ______________________________
Group *or* FECA Number: ______________________________
Phone Number: (   ) ______________ Ext: ________
Adjuster *or* Contact Name: ______________________________
Claims Address: ______________________________
City: ______________ State: ______ Zip: ________

Emergency Contact:

Name: ______________________________
Relationship to Child: ______________________________
Phone: (   ) ______________ O Home O Cell
Office Phone: (   ) ______________ Ext: ______
Pediatrician/PCP's Name: ______________________________

Lifestyle Information:

How would you rate your child's ability to play or exert themselves physically without known limitations or restrictions or discomfort?

O Excellent O Very Good O Good O Average O Poor

How do you rate your child's diet and quality of food intake?

O Excellent O Very Good O Good O Average O Poor

How do you rate your awareness and effort to avoid environmental chemicals and toxins for your child?

O Excellent O Very Good O Good O Average O Poor

How do you rate your child's ability to handle psychological, emotional, social, school and home stressors?

O Excellent O Very Good O Good O Average O Poor

On a scale (1 worst, 10 best) how would you rank your child's overall health & wellness status?

O1 O2 O3 O4 O5 O6 O7 O8 O9 O10

On a scale (1 least, 10 most) how would you rank your priority for your child's health?

O1 O2 O3 O4 O5 O6 O7 O8 O9 O10

Subluxation Related Complaints:

The goal of your child's chiropractic evaluation is to identify neurological stress and abnormal neuro-structural patterns called spinal subluxations. Although chiropractic care is not a treatment for any specific medical condition it is common for spinal subluxations to be directly or indirectly related to many of the following child related conditions. Please check if your child has any of the following:

- O Back Pain / Neck Pain / Growing Pains / Injury
- O Poor Posture / Scoliosis
- O Headaches / Migraines
- O Frequent Colds / Weak Immune System
- O Ear Aches / Ear Infections
- O Behavior Concerns/ Social Concerns
- O GERD / Acid Reflux
- O Constipation / Diarrhea / Digestive Issues
- O Focus Concerns / ADHD / Learning Disabilities
- O Autism Spectrum Disorders / Neuro-Sensory Dysfunction
- O Bedwetting / Enuresis
- O Seizures / Neurological Ticks / Anxiety / Stress Issues
- O Poor Coordination / Difficulty with Sports
- O Abnormal Sleep Patterns
- O Skin Problem / Rash / Eczema
- O Allergies / Intolerances to Foods

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Child's Name: ____________ Date: ________

Pregnancy and Peri-Natal History:

Please provide us with information as it relates to your pregnancy with this child by checking all that apply:

- O Accident While Pregnant
- O Alcohol Consumption
- O Amniocentesis
- O Breech/Abnormal Position
- O Chemical Exposure
- O Frequent Ultrasounds
- O Genetic Testing
- O Gestational Diabetes
- O Group-B Strep Positive
- O Hypertension
- O Bacterial or Viral Infection
- O Yeast/fungal Infection
- O Morning Sickness/Nausea
- O Placenta Abruptio
- O Placenta Previa
- O Poor Nutrition
- O Pre-Eclampsia
- O Prescription Medication
- O Radiation Exposure
- O Recreational Drug Use
- O Rhogam Injection
- O Swelling or Edema
- O Pre-Natal Vitamins
- O Unknown/Adopted

Please check all that apply in regards to your child's vaccine history:

- O Up-to-Date
- O Partial
- O Delaying
- O Conscientious Objector
- O Concerned/Unknown
- O Vaccine Reaction(s)

Please check all that apply in regards to your labor and the birth process with this child:

- O Fetal Monitoring
- O Breech/Abnormal Position
- O Cord Around Neck
- O Labor Induced
- O Rupture of Membranes
- O Pitocin Administered
- O Long and/or Difficult Labor
- O Antibiotics Administered
- O Pain Medication
- O Epidural
- O Lack of Fetal Decent
- O Lack of Progression
- O Fetal Distress
- O Meconium
- O Forceps
- O Suction Device
- O Obstetrical Pulling
- O Cesarean Section

Choose all that apply to your child as a newborn:

- O Premature
- O Poor Sleeping
- O Jaundice
- O Low APGAR Score
- O Failure to Thrive
- O Colic
- O Resuscitation Required
- O Prolonged Cranial Distortion
- O Difficulty Nursing/Latching
- O Meconium Aspiration
- O Antibiotic Administered
- O Circumcised
- O Breast Fed
- O Formula Fed

Family History:

- O Arthritis
- O Cancer
- O Cardiovascular/ Heart Disease
- O Diabetes
- O Hypertension
- O Genetic Disorder
- O Unknown/ Adopted

Developmental & Neurosensory

Please answer the following questions as it pertains (Frequent, Occasionally or Rarely) to your child's behaviors:

Question:	Freq	Occ	Rare
1a. Avoids busy places/crowds?	O	O	O
1a. Dislikes tags & tight clothes?	O	O	O
1s. Unaware of being banged into?	O	O	O
1s. Unable to keep hands to self?	O	O	O
2a. Dislikes strong smelling things?	O	O	O
2s. Constantly smells everything?	O	O	O
3a. Covers ears to avoid noises?	O	O	O
3s. Seems to ignore you often?	O	O	O
4a. Has difficulty/avoids reading?	O	O	O
4a. Hesitates to climb/use stairs?	O	O	O
4a. Dislikes/avoids bright lights?	O	O	O
4s. Squints/turns head to see?	O	O	O
5a. Gets motion sickness easily?	O	O	O
5a. Avoids movement activities?	O	O	O
5s. Difficulty sitting still?	O	O	O
5s. Loves to spin, jump & swing?	O	O	O
6a. Difficult to hop / skip / jump?	O	O	O
6a. Frequently appears clumsy?	O	O	O
6s. Likes heavy blankets?	O	O	O
6s. Frequently kicks/taps things?	O	O	O
7a. Dislikes playing in groups?	O	O	O
7a. Doesn't express needs well?	O	O	O
7s. Is advanced academically?	O	O	O

Treatment History:

Please list any additional care or relative services that your child has received:

____
____
____
____

Please list any supplements and/or vitamins that your child is currently taking:

____
____
____
____

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Child's Name: ____________________ Date: __________

Infant Health History (ROS):

Constitutional:
- O Fever
- O Headache
- O Recent Trauma
- O Stressed/Anxiety
- O Fatigue/Lethargy
- O Poor Sleep
- O Loss of Appetite
- O Weight Loss

EENT:
- O Excessive Tearing
- O Eye infections
- O Poor Eye Control
- O Poor Hearing
- O Ear Aches/Infection
- O Discharge from Ear
- O Poor Smell
- O Nasal Congestion
- O Gags Easily
- O Difficult Speech
- O Spots on Tongue
- O Tooth Decay
- O Gum Disease

Respiratory:
- O Difficulty Breathing
- O Shortness of Breath
- O Asthma / Wheeze
- O Sputum
- O Chronic Cough

Genital:
- O Testicular Problems
- O Gonadal Mass
- O Genital Rash
- O Vaginal Discharge
- O Yeast Infections
- O Breast Mass
- O Early Onset Puberty

Integumentary:
- O Skin Rash/Hives
- O Eczema
- O Bruises Easy
- O Scars
- O Skin Masses/Bumps
- O Skin/Hair/Nail Changes

Musculoskeletal:
- O Swelling of Muscles/Joints
- O Limited Range of Motion
- O Chronic Injury/Complaint

Neurological:
- O Seizures Convulsions
- O Neurological Ticks
- O Lightheaded/Dizziness
- O Tremors
- O Clumsy/Poor Balance

Cardiovascular:
- O Poor Circulation
- O Chest Pain
- O Extremity Swelling
- O Abnormal Heart Rhythm

Immunological:
- O Food Intolerance
- O Environmental Intolerance
- O Allergy
- O Lymph Node Enlargement
- O Meningitis / Serious Infection
- O Weak Immune System

Gastrointestinal:
- O Bloating
- O Constipation
- O Diarrhea
- O Stomach Tenderness/Aches
- O Weight Loss/Loss of Appetite
- O Vomiting
- O Bloody / Tarry Stools
- O Irritable Bowel Synd. (IBS)
- O Crohn's / Ulcerative Colitis
- O Eating Disorder

Endocrine:
- O Neck or Thyroid Mass
- O Abnormal Growth Patterns
- O Excessive Sweating

Urinary:
- O Difficult Urination
- O Foul Smelling Urine
- O Blood in Urine
- O Painful Urination
- O Kidney Problems

Medical History

*Please list any **Prescription Medications** your child takes:*

____
____
____

*Please list **any Surgical Procedures** your child has had:*

____
____
____

*Has your child ever needed any **Emergency Services**?*

____
____
____

*List any known **Allergies** that your child currently has:*

____
____
____

Minor Consent

Consent for Evaluation and Treatment

of a Minor Child:

I hereby authorize the Doctor to treat my child's conditions as he/she deems appropriate through the use of chiropractic adjustments and related services. Furthermore, the Doctor will not be held responsible for any pre-existing medically diagnosed conditions, nor for any medical diagnosis.

"I hereby authorize the Doctor and whomever he/she may designate as his/her associate to administer chiropractic care as he/she deems necessary to my child"

Child's Name: ______________________________

Parent/Guardian Name: ______________________

► **Guardian Signature:** ______________________

Date: __________________