



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? Email Text

Insurance Information:

Do you expect insurance to contribute to your child's care? Yes 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: _____

Lifestyle Information:

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

- Excellent Very Good Good Average Poor

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

- Excellent Very Good Good Average Poor

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

- Excellent Very Good Good Average Poor

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

- Excellent Very Good Good Average Poor

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

- 1 2 3 4 5 6 7 8 9 10

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

- 1 2 3 4 5 6 7 8 9 10

Emergency Contact:

Name: _____

Relationship to Child: _____

Phone: () _____ Home Cell

Office Phone: () _____ Ext: _____

Pediatrician/PCP's Name: _____

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:

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

Pregnancy and Peri-Natal History:

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

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

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

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

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

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

Choose all that apply to your child as a newborn:

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

Child's Name: _____ Date: _____

Family History:

- Arthritis
- Cancer
- Cardiovascular/ Heart Disease
- Diabetes
- Hypertension
- Genetic Disorder
- 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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1a. Dislikes tags & tight clothes?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1s. Unaware of being banged into?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1s. Unable to keep hands to self?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2a. Dislikes strong smelling things?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2s. Constantly smells everything?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3a. Covers ears to avoid noises?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3s. Seems to ignore you often?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4a. Has difficulty/avoids reading?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4a. Hesitates to climb/use stairs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4a. Dislikes/avoids bright lights?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4s. Squints/turns head to see?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5a. Gets motion sickness easily?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5a. Avoids movement activities?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5s. Difficulty sitting still?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5s. Loves to spin, jump & swing?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6a. Difficult to hop / skip / jump?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6a. Frequently appears clumsy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6s. Likes heavy blankets?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6s. Frequently kicks/taps things?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7a. Dislikes playing in groups?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7a. Doesn't express needs well?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7s. Is advanced academically?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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:

Infant Health History (ROS):

Constitutional:

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

EENT:

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

Respiratory:

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

Genital:

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

Integumentary:

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

Musculoskeletal:

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

Neurological:

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

Cardiovascular:

- Poor Circulation
- Chest Pain
- Extremity Swelling
- Abnormal Heart Rhythm

Immunological:

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

Gastrointestinal:

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

Endocrine:

- Neck or Thyroid Mass
- Abnormal Growth Patterns
- Excessive Sweating

Urinary:

- Difficult Urination
- Foul Smelling Urine
- Blood in Urine
- Painful Urination
- 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: _____