

# Riverside Chiropractic Health & Nutrition Center

Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_ D.O.B \_\_\_\_\_ Grade \_\_\_\_\_

1. Spinal problems can cause a variety of health problems, please check the health complaint(s) your child is currently experiencing or experiences on a periodic basis:

- |                                     |   |   |  |
|-------------------------------------|---|---|--|
| <input type="checkbox"/> Neck Pain  | <input type="checkbox"/> Asthma         | <input type="checkbox"/> Frequent Colds   | <input type="checkbox"/> Skin Problems   |
| <input type="checkbox"/> Back Pain  | <input type="checkbox"/> Allergies      | <input type="checkbox"/> Spinal Curvature | <input type="checkbox"/> Chronic Fatigue |
| <input type="checkbox"/> Headaches  | <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Indigestion      | <input type="checkbox"/> ADD/ADHD        |
| <input type="checkbox"/> Bedwetting | <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Arthritis        | <input type="checkbox"/> _____           |

2. What is your child's primary health complaint? \_\_\_\_\_

3. Research shows that spinal problems can begin at birth, how old was your child the first time she received chiropractic care

- Never     0-2 Years     2-5 Years     5-12 Years

4. Difficult, long and/or doctor assisted births can cause spinal misalignments. Was your child born

- Vaginally     C Section     Forceps     Suction cup     Other

5. How long was the actual labor?  0-3 hour's     3-21 hour's     12-24 hour's     > 24 hour's

6. Have you ever been told your child has a spinal curvature?  Yes     No

7. Poor posture can lead to poor health and can indicate spinal problems, how would you rate your child's posture?

Poor - 12    3    4    5    6    7    8    9    10 - Very good

8. Did your child have early health challenges such as  Colic     irritability     frequent ear infections?

9. Does your child have health problems that concern you? \_\_\_\_\_

10. Do you miss work often because of your child's health?  Yes     No

11. Do you worry often of your child's health?  Yes     No

12. Do you have any health problems that affect your family?  Yes     No

13. Is your child currently taking any prescription drugs?  Yes     No

14. Is this visit related to any falls, sports impacts, or auto accidents?  Yes     No

Date of incident \_\_\_\_\_

15. If the Dr. feels like your child can benefit from chiropractic care, are you willing to follow her recommendations?

Yes     No \_\_\_\_\_

Parent/guardian \_\_\_\_\_

Dr. \_\_\_\_\_

Date \_\_\_\_\_

Date \_\_\_\_\_