DR. MIKE RUMPEL B.Sc., D.C.
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Children's Screening Questionnaire

Name: ____________________ Parent's names ____________________

Mailing Address: ____________________

Postal Code: ____________ City: ____________ Prov. ____________

Phone: ____________________ Date of Birth: (dd/mm/yy) ____________

Day phone for Parent: ____________ Personal Health Card # ____________

Who may we thank for referring you to our office? ____________________

During pregnancy was mom on any medication, consume any alcohol, or smoke? ____________

____

Was there any back pain during the pregnancy? ____________________

Were you basically ill? (Colds, Flu, allergies etc.) If so, what? ____________________

Regarding labour/birth:

How long was labour? ____________ APGAR Score ____________

Was it chemically induced?	YES	NO	Did Mom have an epidural?	YES	NO
Doctor assisted?	YES	NO	Did Baby have mis-shaped head or skull?	YES	NO
Was a C-Section performed?	YES	NO			
Were forceps used?	YES	NO			
Was vacuum suction used?	YES	NO			
Were you lying down?	YES	NO			
Were your legs in stirrups?	YES	NO			
Was the baby premature?	YES	NO	if yes, weeks ______ weight ____________		

Has your child suffered any health problems such as: (circle)

Headaches	Meningitis	Allergies	Frequent fevers
Diarrhea	Ear Problems	Constipation	Hyperactivity
Fatigue	Colic	Irritability	Asthma
Sleeping Disorders	Rashes	Bed Wetting	Leg/"growing pains"
Breathing Problems	Frequent colds	Digestive Problems	
Flu	Milk/lactose or other food intolerances		

Others: ____

Name of Medical Doctor, last visit date / reason: ____________________

Name of previous Doctor of Chiropractic/ last visit date?: ____________________

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Are there any health concerns, diseases or illnesses of related family members? ____________________

____

Was baby breast-fed?	YES	NO
Does / did baby favor one side?	YES	NO
Did mother take any medications during pregnancy/delivery?	YES	NO
Have you chosen to vaccinate?	YES	NO

If yes, which ones, and any negative reactions or side effects?

____

Regarding your child today:

Any head/skull injuries or impact?	YES	NO	
Is your child accident prone?	YES	NO	
Has the child had any falls down steps?	YES	NO	
Has the child ever fallen from heights over 2 feet?	YES	NO	
Has your child been involved in a car accident?	YES	NO	
Has your child been hospitalized or had surgery?	YES	NO	
Has your child ever had broken bones or injuries?	YES	NO	
Has your child ever been on any medication?	YES	NO	
Has your child had a scoliosis exam?	YES	NO	If yes, when? _______
Does your child have learning disorders?	YES	NO	
Does your child have difficulty sleeping?	YES	NO	
Does your child have poor posture?	YES	NO	
Does your child have problems associating with friends?	YES	NO	
Is your child nervous?	YES	NO	
Does your child show signs of twitching?	YES	NO	
Does your child talk excessively to themselves?	YES	NO	

If you could improve any aspect of your child's health or behavior, what would it be?

____

____

____

I ________________________________ (parent or guardian) grant permission for Dr. Mike Rumpel to examine and/or provide chiropractic care for the above named child.

Signature ______________________________

Date ______________________________

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