

Children's Chiropractic Health Questionnaire

From birth through age 17

Today's Date: _____

Child's Name: _____ Sex: _____ Birth Date: _____

Parents' Names: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Parents' e-mail: _____

Home Phone: _____ Parents' cell phones: _____

If school age, what grade level is your child? _____

What School? _____

What health concerns brought your child to our office?

How did your family hear about our office? _____

Has your child ever been to a chiropractor before? _____

Please rate your child's overall health: 1 2 3 4 5 6 7 8 9 10
Poor Excellent

Parental / Guardian Consent

I give Dr. Davis permission to render chiropractic care to _____
(for whom I am responsible). I understand that this care may include chiropractic
examinations, adjustments and the recommendations of x-rays if needed.

Parent/Legal Guardian Signature

Date