Kids LIVE WELL CHIROPRACTIC

# Child Health Questionnaire

Name:_____ Address:_____

City:_____ State: _____ Zip: _____

Telephone home: _____ Telephone work: _____

Email address: _____ Cell Phone: _____

Mom and Dads Name: _____ Birth date: _____

Height: _____ Weight: _____

Health insurance name: _____

Names and ages of siblings: _____

Present medical doctor : _____ Present medical clinic: _____

Previous Chiropractor :_____

Last visit date: _____ Reason for leaving : _____

How did you hear about our office?

___ Referral from friend/family/co-worker (name please _____)

___internet ___ yellow pages ___drive by ___ other

What is your child's main reason for this visit?

_____

_____

How long has your child suffered with this problem?

_____

How did it start? _____

Could have it been caused by trauma auto accident? _____ If yes, please explain: _____

_____

What have you tried to get rid of this problem? _____

_____

What gives your child temporary relief?

_____

What makes it worse? _____

Other professionals seen for main health concern: _____

Treatment and results: _____

Any additional complaints? _____

_____

Do you have any other health problems we should be aware of? _____

_____

Does it interfere with your child's sleep? _____ eating? _____ daily routine? _____

Is the problem worse during a certain time of the day?_____ If so, when? _____

What effect doe this problem have on your child's body functions? _____

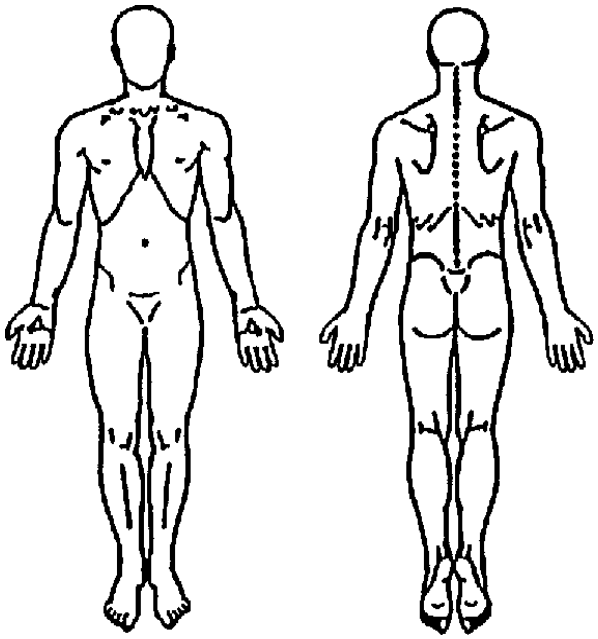
_____

On his/her participation in daily activities? _____

_____

**Show areas of pain or unusual feeling. Mark the areas on the diagram below and please include altered sensation and referral pain.**

**Include all affected areas.**



## PRENATAL HISTORY

Name of obstetrician/Midwife:

Complications during pregnancy? YES NO If yes, list: _____

Complications during delivery? YES NO If yes, list: _____

Medications during pregnancy/delivery: YES NO If yes, number: _____

Epidural used? YES NO

Location of birth: HOSPITAL BIRTHING CENTER HOME

Birth intervention: FORCEPS VACUUM EXTRACTION
CESSARIAN SECTION – emergency or planned

Apgar scores at birth: _____At 5 Min:,_____ Cigarette/Alcohol use during pregnancy? YES NO

Genetic disorders or disabilities? YES NO If yes, list: _____

Did mom consume alcohol during pregnancy? YES NO If so how much? _____

Did mom consume alcohol during pregnancy? YES NO If so how much? _____

Birth Weight: _____ Birth Length:_____

## FEEDING HISTORY

Breast fed?_____ If yes, how long? _____ Formula fed? _____ If yes, how long? _____

If breastfed any difficulty with lactation? _____

Introduced solids at: _____ months, cow's milk at _____ months

Food/juice allergies or intolerances? YES NO If yes, list? _____

## DEVELOPMENTAL HISTORY

During the following times your child's spine is most vulnerable to stress and should routinely be checked by a doctor of chiropractic for prevention and early detection of vertebral subluxation (spinal nerve interference). At what age was your child able to:

_____ Respond to Sound _____ Cross Crawl

_____ Respond to Visual Stimuli _____ Stand Alone

_____ Sit Up _____Walk Alone

According to the National Safety Council, approximately 50% of children fall from a high place during their first year of life (i.e. a bed, a changing table, down stairs, etc.) Was this the case with your child? YES NO

Is/has your child been involved in any high impact or contact sports (i.e. soccer, football, gymnastics, baseball, cheerleading, martial arts, etc.)? YES NO If yes, list: _____

Has your child ever been involved in a car accident? YES NO If yes, list: _____

Has your child ever been seen on an emergency basis? YES NO If yes, list: _____

Other traumas not described above? YES NO If yes, list: _____

Prior surgery? YES NO If yes, list: _____

**As a baby/toddler, (birth to 4 years), did any of the following occur?**

_____ Fall from a changing table
____ Tumble down stairs
____ Fall out of crib
____ Involved in a car accident
____ Fall of playground Equipment
____ Play in "Jolly Jumper"
____ Frequent ear infections
____ Tonsilitis
____ Reaction to vaccination
____ Frequent crying spells
____ Frequent bouts of diarrhea
____ Constipation
____ Sleeping problems
____ Frequent colds
____ Frequent fevers
____ Colic
____ Did not gain weight
____ Other _____

Please explain the above _____

_____

**As a young child, ( 5-12 years), did any of the following occur?**

____ Fall from a tree
____Fall off a bicycle
____ Fall of playground equipment
____ Sports accidents
____ Car accidents
____ Stomach pains
____ Scoliosis
____ Bed wetting
____ Hyperactivity/Autism
____ Learning difficulties
____ Asthma
____ Allergies
____ Leg/knee pain
____ Other _____

Please explain the above: _____

_____

Any behavioral problems? ___ N ___Y Explain: _____

Any Night Terrors, sleep walking, sleep difficulties? ___N ___Y Explain: _____

_____

Average number of hours of television per week?_____ Computer?_____ Playstation/Gameboy Ect? _____

Tell us about any vaccinations your child has had. _____

_____

Any reactions to vaccinations? _____

Do you believe your child needs to be fully vaccinated to attend school/daycare? ____yes _____no

Describe any hospital stays:

_____

_____

In case of emergency please notify: _____

Relationship and telephone number: _____

At our office we are not only interested in your health and well being, but the health and well being of your family as well. Please mention any health conditions or concerns you may have about your…

Siblings: _____

Mother: _____

Father: _____

Other: _____

## AUTHORIZATION FOR CARE OF MINOR

I authorize this office and its Doctors to administer care to my child. I authorize the doctors to take x-rays, perform an exam and administer treatment. I clearly understand and agree I am personally responsible for payment of any fees not covered by my insurance.

Signature: _____ Date: _____

## TERMS OF ACCEPTANCE

When a patient seeks chiropractic care and we accept a patient for such care, it is essential for both to be working for the same objective. Chiropractic has only one goal. It is important that each patient understands both the objective and the method that which will be used to attain it. This will prevent any confusion or disappointment.

**ADJUSTMENT**: The adjustment is the specific application of forces to facilitate the body's correction of a vertebral subluxation. Our chiropractic method of correction is by specific adjustment to the spine.

**HEALTH**: The state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.

**VERTEBRAL SUBLUXATION**: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer the diagnosis or treatment of any disease. **We only offer to diagnose either vertebral subluxation complex and/or neuro-musculoskeletal conditions.** However, if during the course of a chiropractic spinal examination we encounter unusual findings which are outside the scope of practice for a Doctor of Chiropractic, we will advise you. If you desire advice, diagnosis, or treatment for those findings, we will recommend that you seek the services of another health care provider.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatments prescribed by others. **OUR ONLY PRACTICE OBJECTIVE is to eliminate major interference to the expression of the body's innate wisdom.** Our only method is the specific adjustment to correct vertebral subluxation. However, we may use other procedures to help your body hold those adjustments.

I, _____have read and fully understand the above statements.

(parent printed name)

Signature: _____ Date: _____

(parent signature)

**Place a mark on the YES or NO to indicate if your child has had or have a family history of any of these**

| | | | | | | |
|---|---|---|---|---|---|---|
| Aids/HIV | ◯Yes | ◯No | ◯You | ◯Family History | ◯Both |
| Alcoholism | ◯Yes | ◯No | ◯You | ◯Family History | ◯Both |
| Allergy Shots | ◯Yes | ◯No | ◯You | ◯Family History | ◯Both |
| Anemia | ◯Yes | ◯No | ◯You | ◯Family History | ◯Both |
| Appendicitits | ◯Yes | ◯No | ◯You | ◯Family History | ◯Both |
| Arthritis | ◯Yes | ◯No | ◯You | ◯Family History | ◯Both |
| Asthma | ◯Yes | ◯No | ◯You | ◯Family History | ◯Both |
| Bleeding Disorder | ◯Yes | ◯No | ◯You | ◯Family History | ◯Both |
| Breast Lump | ◯Yes | ◯No | ◯You | ◯Family History | ◯Both |
| Bronchitis | ◯Yes | ◯No | ◯You | ◯Family History | ◯Both |
| Bulimia | ◯Yes | ◯No | ◯You | ◯Family History | ◯Both |
| Cancer | ◯Yes | ◯No | ◯You | ◯Family History | ◯Both |
| Cataracts | ◯Yes | ◯No | ◯You | ◯Family History | ◯Both |
| Chemical Depend | ◯Yes | ◯No | ◯You | ◯Family History | ◯Both |
| Chicken Pox | ◯Yes | ◯No | ◯You | ◯Family History | ◯Both |
| Depression | ◯Yes | ◯No | ◯You | ◯Family History | ◯Both |
| Diabetes | ◯Yes | ◯No | ◯You | ◯Family History | ◯Both |
| Emphysema | ◯Yes | ◯No | ◯You | ◯Family History | ◯Both |
| Epilepsy | ◯Yes | ◯No | ◯You | ◯Family History | ◯Both |
| Fractures | ◯Yes | ◯No | ◯You | ◯Family History | ◯Both |
| Glaucoma | ◯Yes | ◯No | ◯You | ◯Family History | ◯Both |
| Goiter | ◯Yes | ◯No | ◯You | ◯Family History | ◯Both |
| Gout | ◯Yes | ◯No | ◯You | ◯Family History | ◯Both |
| Heart Disease | ◯Yes | ◯No | ◯You | ◯Family History | ◯Both |
| Hepatitis | ◯Yes | ◯No | ◯You | ◯Family History | ◯Both |
| Hernia | ◯Yes | ◯No | ◯You | ◯Family History | ◯Both |
| Herniated Disk | ◯Yes | ◯No | ◯You | ◯Family History | ◯Both |
| High Cholesterol | ◯Yes | ◯No | ◯You | ◯Family History | ◯Both |
| Kidney Disease | ◯Yes | ◯No | ◯You | ◯Family History | ◯Both |

| | | | |
|---|---|---|---|
| Liver Disease | ◯Yes | ◯No | ◯You ◯Family History ◯Both |
| Measles | ◯Yes | ◯No | ◯You ◯Family History ◯Both |
| Migraine Headache | ◯Yes | ◯No | ◯You ◯Family History ◯Both |
| Miscarriage | ◯Yes | ◯No | ◯You ◯Family History ◯Both |
| Mononucleosis | ◯Yes | ◯No | ◯You ◯Family History ◯Both |
| Multiple Sclerosis | ◯Yes | ◯No | ◯You ◯Family History ◯Both |
| Mumps | ◯Yes | ◯No | ◯You ◯Family History ◯Both |
| Osteoporosis | ◯Yes | ◯No | ◯You ◯Family History ◯Both |
| Pacemaker | ◯Yes | ◯No | ◯You ◯Family History ◯Both |
| Parkinson's Disease | ◯Yes | ◯No | ◯You ◯Family History ◯Both |
| Pinched Nerve | ◯Yes | ◯No | ◯You ◯Family History ◯Both |
| Pneumonia | ◯Yes | ◯No | ◯You ◯Family History ◯Both |
| Polio | ◯Yes | ◯No | ◯You ◯Family History ◯Both |
| Prostate Problem | ◯Yes | ◯No | ◯You ◯Family History ◯Both |
| Psychiatric Care | ◯Yes | ◯No | ◯You ◯Family History ◯Both |
| Rheumatoid Arthritis | ◯Yes | ◯No | ◯You ◯Family History ◯Both |
| Rheumatic Fever | ◯Yes | ◯No | ◯You ◯Family History ◯Both |
| Scarlet Fever | ◯Yes | ◯No | ◯You ◯Family History ◯Both |
| Stroke | ◯Yes | ◯No | ◯You ◯Family History ◯Both |
| Thyroid Problems | ◯Yes | ◯No | ◯You ◯Family History ◯Both |
| Tonsillitis | ◯Yes | ◯No | ◯You ◯Family History ◯Both |
| Tuberculosis | ◯Yes | ◯No | ◯You ◯Family History ◯Both |
| Tumors/Growths | ◯Yes | ◯No | ◯You ◯Family History ◯Both |
| Ulcers | ◯Yes | ◯No | ◯You ◯Family History ◯Both |
| Urinary Infections | ◯Yes | ◯No | ◯You ◯Family History ◯Both |
| Whooping Cough | ◯Yes | ◯No | ◯You ◯Family History ◯Both |

Other: _____

| Medication Name | Mg per dose | Number of times per day | Total Daily Dose |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| Supplements/Vitamin | Mg per dose | Number of times per day | Total Daily Dose |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| Allergies To Medication | | | |
| | | | |
| | | | |
| Allergies General | | | |
| | | | |
| | | | |
| | | | |

| FOR OFFICE USE ONLY | |
|---|---|
| Ethnicity | Caucasian Hispanic Other |
| Gender | Male Female |
| Smoker | Yes No Former |
| Height | inches |
| Weight | lbs |
| Blood Pressure | / |

# LIVE WELL
## CHIROPRACTIC