



# Kids LIVE WELL — CHIROPRACTIC —

## Child Health Questionnaire

Child Name: \_\_\_\_\_ Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Telephone home: \_\_\_\_\_ Birth date: \_\_\_\_\_  
 Email address: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
 Child height: \_\_\_\_\_ Child weight: \_\_\_\_\_

Mom and Dad's Name: \_\_\_\_\_

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/ (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? \_\_\_\_\_

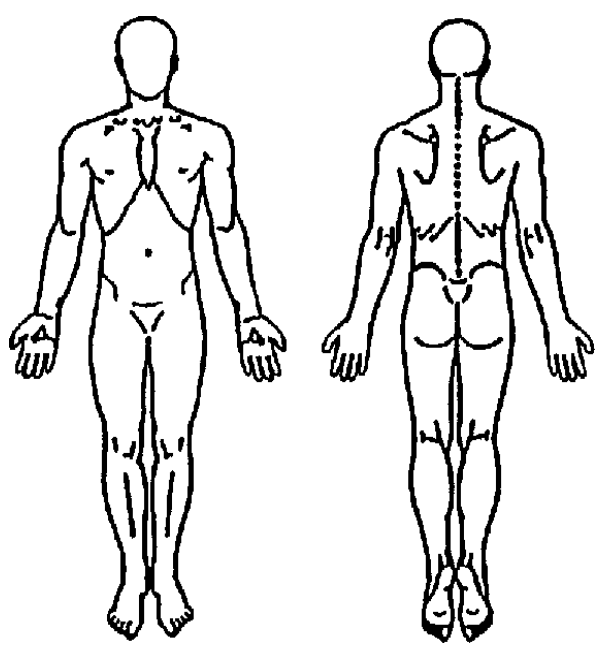
Is the problem worse during a certain time of the day? \_\_\_\_\_ If so, when? \_\_\_\_\_

What effect does 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.**





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

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

Please explain the above \_\_\_\_\_

\_\_\_\_\_

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

- |   |  |
|---|--|
| <input type="checkbox"/> Fall from a tree             | <input type="checkbox"/> Bed wetting           |
| <input type="checkbox"/> Fall off a bicycle           | <input type="checkbox"/> Hyperactivity/Autism  |
| <input type="checkbox"/> Fall of playground equipment | <input type="checkbox"/> Learning difficulties |
| <input type="checkbox"/> Sports accidents             | <input type="checkbox"/> Asthma                |
| <input type="checkbox"/> Car accidents                | <input type="checkbox"/> Allergies             |
| <input type="checkbox"/> Stomach pains                | <input type="checkbox"/> Leg/knee pain         |
| <input type="checkbox"/> Scoliosis                    | <input type="checkbox"/> 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          | <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> You <input type="radio"/> Family History <input type="radio"/> Both |
| Alcoholism        | <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> You <input type="radio"/> Family History <input type="radio"/> Both |
| Allergy Shots     | <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> You <input type="radio"/> Family History <input type="radio"/> Both |
| Anemia            | <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> You <input type="radio"/> Family History <input type="radio"/> Both |
| Appendicitis      | <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> You <input type="radio"/> Family History <input type="radio"/> Both |
| Arthritis         | <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> You <input type="radio"/> Family History <input type="radio"/> Both |
| Asthma            | <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> You <input type="radio"/> Family History <input type="radio"/> Both |
| Bleeding Disorder | <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> You <input type="radio"/> Family History <input type="radio"/> Both |
| Breast Lump       | <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> You <input type="radio"/> Family History <input type="radio"/> Both |
| Bronchitis        | <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> You <input type="radio"/> Family History <input type="radio"/> Both |
| Bulimia           | <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> You <input type="radio"/> Family History <input type="radio"/> Both |
| Cancer            | <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> You <input type="radio"/> Family History <input type="radio"/> Both |
| Cataracts         | <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> You <input type="radio"/> Family History <input type="radio"/> Both |
| Chemical Depend   | <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> You <input type="radio"/> Family History <input type="radio"/> Both |
| Chicken Pox       | <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> You <input type="radio"/> Family History <input type="radio"/> Both |
| Depression        | <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> You <input type="radio"/> Family History <input type="radio"/> Both |
| Diabetes          | <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> You <input type="radio"/> Family History <input type="radio"/> Both |
| Emphysema         | <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> You <input type="radio"/> Family History <input type="radio"/> Both |
| Epilepsy          | <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> You <input type="radio"/> Family History <input type="radio"/> Both |
| Fractures         | <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> You <input type="radio"/> Family History <input type="radio"/> Both |
| Glaucoma          | <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> You <input type="radio"/> Family History <input type="radio"/> Both |
| Goiter            | <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> You <input type="radio"/> Family History <input type="radio"/> Both |
| Gout              | <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> You <input type="radio"/> Family History <input type="radio"/> Both |
| Heart Disease     | <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> You <input type="radio"/> Family History <input type="radio"/> Both |
| Hepatitis         | <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> You <input type="radio"/> Family History <input type="radio"/> Both |
| Hernia            | <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> You <input type="radio"/> Family History <input type="radio"/> Both |
| Herniated Disk    | <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> You <input type="radio"/> Family History <input type="radio"/> Both |
| High Cholesterol  | <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> You <input type="radio"/> Family History <input type="radio"/> Both |
| Kidney Disease    | <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> You <input type="radio"/> Family History <input type="radio"/> 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	/