GREATER GOOD
CHIROPRACTIC CARE

## Child Chiropractic Health Questionnaire

Name _____ Home phone _____

Address _____ Cell Phone _____

E-mail Address _____

City, State, Zip _____

Birth date _____ Age _____ Grade _____

1. Most patients are referred to our office by a caring family member or friend. What made you decide to visit our office? Friend/Family Member Name _____
□ Telephone Call □ Yellow Pages □ Sign □ Website □ Presentation □ E-mail

2. Research shows that spinal problems often begin at birth. How old was your child when they received their first chiropractic checkup? _____ □ Never

3. Difficult, long and/or doctor-assisted births can cause spinal misalignments. Was your child born by C-section, forceps, suction cup or other device? (Please circle) □ YES □ NO

4. How long was the actual labor and delivery time? _____

5. Have you ever been told that your child has a spinal curvature, spinal arthritis, or inherited spinal problem? □ YES □ NO _____

6. Poor posture leads to poor health and often indicates a spinal problem. How would you rate your child's posture? Poor - 1 2 3 4 5 6 7 8 9 10 - Excellent

7. Did your child have early health challenges such as colic or frequent ear infections? □ YES □ NO

8. Does your child suffer from any of the following: allergies, sinus problems, bed-wetting, difficulty concentrating, attention deficit disorder? (Please circle)

9. Does your child have other health problems that concern you? _____
_____

10. Do you miss work or sleep often due to your child's illnesses? □ YES □ NO

11. Do you worry often about your child's health? □ YES □ NO

12. Do you any have health problems that affect your family? Please list _____
_____

13. Prescription medications may cause various side effects, hide the severity of health problems and hinder the body's ability to heal. What medications is your child currently taking?

_____

14. Falls, sports impacts and auto accidents can cause serious spinal problems. Is this visit related to an auto accident or injury? □ YES □ NO Date of Incident _____

15. If the doctor feels that your child will benefit from chiropractic care are you willing to follow his/her recommendations? □ YES □ NO

16. Would you like to receive our weekly health and wellness newsletter via e-mail? □ YES □ NO

**The above information is true and accurate to the best of my knowledge.**

**Parent/Guardian Signature_____ Date_____**

# WRITTEN CONSENT FOR A CHILD

NAME OF PATIENT WHO IS A MINOR/CHILD _____

I AUTHORIZE DR. CONNOR LAVALLIE AND ANY AND ALL GREATER GOOD CHIROPRACTIC STAFF TO PERFORM DIAGNOSTIC PROCEDURES, RADIOGRAPHIC EVALUATIONS, RENDER CHIROPRACTIC CARE AND PERFORM CHIROPRACTIC ADJUSTMENTS TO MY MINOR/CHILD.

AS OF THIS DATE, I HAVE THE LEGAL RIGHT TO SELECT AND AUTHORIZE HEALTH CARE SERVICES FOR MY MINOR/CHILD. OF MY AUTHORITY TO SELECT AND AUTHORIZE CARE IS REVOKED OR ALTERED, I WILL IMMEDIATELY NOTIFY GREATER GOOD CHIROPRACTIC CARE.

_____ _____

DATE GUARDIAN SIGNATURE **AND** RELATIONSHIP TO MINOR /CHILD

_____ _____

**WITNESS SIGNATURE (OFFICE STAFF)** **DATE**