



# Child Chiropractic Health Questionnaire

*"A Healthy Spine Means a Healthier You!"*

**Welcome to Our Office! Please answer the following questions:**

Name \_\_\_\_\_ Home Phone \_\_\_\_\_  
Address \_\_\_\_\_ Work Phone \_\_\_\_\_  
City, State, Zip \_\_\_\_\_ Cell Phone \_\_\_\_\_  
E-mail Address \_\_\_\_\_  
Birth date \_\_\_\_\_ Age \_\_\_\_\_ Grade in School \_\_\_\_\_

- Spinal problems can cause a variety of health problems. Please check the health complaint(s) your child is currently experiencing or experiences on a periodic basis:  

<input type="radio"/> Neck Pain	<input type="radio"/> Asthma	<input type="radio"/> Frequent Colds	<input type="radio"/> Skin Problems
<input type="radio"/> Back Pain	<input type="radio"/> Allergies	<input type="radio"/> Spinal Curvature	<input type="radio"/> Chronic Fatigue
<input type="radio"/> Headaches	<input type="radio"/> Sinus Problems	<input type="radio"/> Indigestion	<input type="radio"/> ADD/ADHD
<input type="radio"/> Bedwetting	<input type="radio"/> Ear Infections	<input type="radio"/> Arthritis	<input type="radio"/> _____
- What is your child's primary health complaint? \_\_\_\_\_
- Research shows that spinal problems often begin at birth. How old was your child when they received their first chiropractic checkup?  Never  0 – 2 years  2 – 5 years  5 – 12 years
- Difficult, long and/or doctor-assisted births can cause spinal misalignments. Was your child born vaginally, by C-section, forceps, suction cup or other device? (Please circle one)
- How long was the actual labor and delivery time?  0 – 3 hours  3 – 12 hours  12 – 24 hours  > 24 hours
- Have you ever been told that your child has a spinal curvature, spinal arthritis, or inherited spinal problem?  
 YES  NO
- Poor posture can lead to poor health and usually indicates a spinal problem. How would you rate your child's posture?  
Poor – 1 2 3 4 5 6 7 8 9 10 – Very Good
- Did your child have early health challenges such as colic, irritability or frequent ear infections?  YES  NO
- Does your child have other health problems that concern you? \_\_\_\_\_
- Do you miss work or sleep often due to your child's illness(s)?  YES  NO
- Do you worry often about your child's health?  YES  NO
- Do you any have health problems that affect your family? Please list \_\_\_\_\_
- Is your child currently taking prescription medication?  YES  NO If so, how many? \_\_\_\_\_
- Falls, sports impacts and auto accidents can cause serious spinal problems. Is this visit related to a fall, sports impact, auto accident or injury?  YES  NO Date of Incident \_\_\_\_\_
- If the doctor feels that your child will benefit from chiropractic care are you willing to follow his/her recommendations?  
 YES  NO \_\_\_\_\_
- How will you be paying for today's visit?  Credit/Debit Card  Cash  Check  Other \_\_\_\_\_

The above information is true and accurate to the best of my knowledge. Copies of any x-rays and reports will be released upon written request, however original x-rays remain the property of the clinic.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_



**HEALTH HISTORY OF FAMILY MEMBERS**

Name \_\_\_\_\_

Date \_\_\_\_\_

The reason for this form is to assist the doctors by providing past/current health history information for their review.

<b>Condition</b>	<b>Self</b>	<b>Father</b>	<b>Mother</b>	<b>Spouse</b>	<b>Brother(s)</b>	<b>Sister(s)</b>	<b>Child(ren)</b>
Allergy/Sinus Trouble							
Arm/Hand/Shoulder Problems							
Arthritis							
Asthma/Emphysema/ Lung Function							
Back Pain							
Blood Pressure							
Cancer							
Cholesterol							
Constipation							
Diabetes							
Digestion (Acid Reflux, Ulcers, etc.)							
Disc Problems							
Fibromyalgia							
Headaches							
Heart Trouble							
Kidney Trouble							
Leg/Foot/Hip Problems							
Migraine							
Muscle Spasms							
Neck Pain							
Nervousness/Anxiety							
Osteoporosis							
Pinched Nerve							
Scoliosis (Curved Spine)							
OTHER (Please Indicate)							