Parent/Child Health Questionnaire

Name of Parent_____

Address _____

_____

City/State/Zip _____

Phone # Work _____(Hours___ to ___)

Home _____

Name of Child_____

Address (if different from parent)

_____

_____

Phone #_____ Sex M F

Date of Birth_____Age _____

Who is responsible for your child's bill? ☐ You ☐ Spouse ☐ Auto Insurance
☐ Personal Health Insurance_____

During pregnancy, were you on medication? Did you smoke or consume any alcoholic beverages?

_____

Was there back pain?_____

_____

Approximately how long was labor?_____

_____

Were you physically ill? (Colds, flu, allergies, German measles, anything like that) _____

If so, what? _____

Regarding Labor:

Was it chemically induced?	☐ Yes	☐ No
Doctor assisted?	☐ Yes	☐ No
Was C-Section performed?	☐ Yes	☐ No
Were forceps used?	☐ Yes	☐ No
Did doctor have hands on the infant?	☐ Yes	☐ No
Were you lying down?	☐ Yes	☐ No
Was family member present?	☐ Yes	☐ No

If yes, who? _____

(95% of all infants were born with hands on or forceps)

Was the baby premature? ☐ Yes ☐ No

If so, what was his/her age and weight? _____

Did your child suffer any health problems, such as:

Headaches	☐ Yes	☐ No	Meningitis	☐ Yes	☐ No
Allergies	☐ Yes	☐ No	Diarrhea	☐ Yes	☐ No
Ear Problems	☐ Yes	☐ No	Constipation	☐ Yes	☐ No
Sleeping Disorders	☐ Yes	☐ No	Colic	☐ Yes	☐ No
Breathing Problems	☐ Yes	☐ No	Rashes	☐ Yes	☐ No
Fatigue	☐ Yes	☐ No	Milk or Lactose Intolerance	☐ Yes	☐ No
Irritability	☐ Yes	☐ No	Bed Wetting	☐ Yes	☐ No
Hyperactivity	☐ Yes	☐ No	Digestive Problems	☐ Yes	☐ No
Frequent Colds	☐ Yes	☐ No	Other: _____		
Flu	☐ Yes	☐ No	_____		
Bloody Noses	☐ Yes	☐ No	_____		

Regarding your child today:

Is your child accident prone: ☐ Yes ☐ No

Has the child had any falls down steps? ☐ Yes ☐ No

Has your child ever fallen from heights over 2 feet? ☐ Yes ☐ No

Has your child ever been involved in a motor vehicle accident? ☐ Yes ☐ No

Has your child ever been hospitalized or had surgery? ☐ Yes ☐ No

Does your child suffer from:

Allergies	☐ Yes	☐ No
Asthma	☐ Yes	☐ No
Headaches	☐ Yes	☐ No

Has your child ever had any broken bones or sprain injuries? ☐ Yes ☐ No

Is your child on any medication? ☐ Yes ☐ No

Has your child had a scoliosis examination by an approved scoliosis determination procedures clinic? ☐ Yes ☐ No

Is your child hyperactive?	☐ Yes	☐ No
Have learning disorders?	☐ Yes	☐ No
Sleeping difficulty?	☐ Yes	☐ No
Poor posture?	☐ Yes	☐ No

Does your child have any problem associating with friends? ☐ Yes ☐ No

Is your child nervous, or has anyone suggested that your child was nervous? ☐ Yes ☐ No

Does your child show any signs of nervousness, twitching or excessive talking to themselves? ☐ Yes ☐ No

If you could improve one aspect of your child's health or behavior, what would it be?_____

_____

_____

DO NOT WRITE BELOW THIS LINE

CHIROPRACTIC ANALYSIS:

DIAGNOSIS:

Patient Accepted ☐ Yes ☐ No ☐ Referred

_____
Doctor's Signature