

Child Chiropractic Health Questionnaire

Name _____ SS# _____ Age _____

Birthdate _____ Address _____

City _____ State _____ Zip _____

Parent/Guardian Contact Name(s) _____

Relation to child _____ Contact phone #: (H) _____

Contact phone #: (W) _____ (C) _____



Most patients are referred to our office by a caring family member or friend. How did you hear

about us? Friend/Family Member (Name) _____ Radio Dinner Talk

Website Health Screening Phone call Other _____

Research shows that spinal misalignments oftentimes begin at birth. How old was your child when they received their first chiropractic checkup? _____ Never

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 any applicable) YES NO

How long was the actual labor and delivery time? _____

Have you ever been told that your child has a spinal curvature, spinal arthritis, or inherited spinal problem? NO

YES (explain) _____

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

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

Does your child suffer from any of the following: Allergies Sinus problems Bed wetting Difficulty concentrating ADD / ADHD Headaches Digestive complications Poor immune system (sick a lot) Aches/pains

Does your child have any other health challenges that concern you? _____

Do you miss work or sleep as a result of your child's health challenges? YES NO Do you worry often about your child's health? YES NO

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

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, and for what health challenge is he/she taking them? _____

Falls, sports injuries, and auto accidents can cause serious spinal problems. Is this visit related to an injury?

YES NO Date of Incident _____

If the doctor feels that chiropractic will help your child, are you willing to follow his/her recommendations?

YES NO

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

Patient Signature _____

Date _____