Date_____

Child Chiropractic Health Questionnaire

Please complete this detailed history form and return it to the receptionist. Should you require any assistance, please let us know. We will be happy to assist.

Information

Child's Name: _____ Parent(s) Name: _____

Home Phone: _____ Parent's Cell Phone(s):_____

E-mail Address_____

Home Address: _____

City: _____State: _____ Zipcode:_____

Child's Birth Date (DOB)_____ 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_____
2. Research shows that spinal issues often begin at birth. How old was your child when they received their first chiropractic checkup?_____ Never_____
3. Difficult, long and/or extensive 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. Falls, sports impacts and auto accidents can cause serious health problems. Is this visit related to an auto accident or injury? Yes No Date of incident_____
8. 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?

   _____

Date_____

The following information is very important because many of the problems that chiropractors work with are caused by stressors

A. History of Birth

Hospital/Birthing Center: r Home rMedical rMidwife Duration of Gestation:_____wks
Was the birth assisted? r Yes rNo If Yes, how? rInduction rForceps rVacuum rC-section
Were medications given to the mother during labor? rYes rNo If Yes,
what?_____

B. Growth and Development

Was child alert and responsive within 12 hours of delivery? rYes rNo If no, why?
_____
At what age did the child: Respond to sound? _____ Follow an object? _____ Hold up head? _____ Vocalize? _____
Sit up alone? _____ Teethe? _____ Crawl? _____ Walk? _____ Do their sleep patterns seem normal? _____

C. Chemical Stressors

At any time during the pregnancy did the mother r Smoke r Drink r Take prescription medication r Have chemical exposure
Was your child breastfed? rYes rNo If yes, then for how long? _____ weeks rmonths ryears
If no, then at what age was formula introduced? _____ Brand? _____
rMilk-based or rSoy-based?
Did your child receive vaccinations? rYes rNo If so which ones?
_____
Did your child react to any vaccines? _____. Has your child had any rounds of antibiotics? _____

D. Psychological Stressors

Any difficulties with lactation? rYes rNo Any problems with bonding? rYes rNo
Does your child have any behavior problems? rYes rNo Describe:
_____
Does your child have difficulties sleeping (e.g. night terrors, sleepwalking, etc) rYes rNo Describe: _____
Did your child go to daycare? rYes rNo From what age? _____ Average number of hours of TV/Computer a week _____

E. Traumatic Stressors

Any evidence of trauma during birth? rBruises rOdd shaped head rStuck in the birth canal rCord around neck
rExcessively fast or short birth rRespiratory Depression Other:
_____
Any falls/accidents during pregnancy? rYes rNo Has the child had any major falls, fractures or stitches? _____
Any hospitalizations? rYes rNo If yes, please explain:
_____

Date_____

Does your child play sports? rYes rNo What sport(s): _____
Beginning Age: _____

Please CIRCLE ALL CURRENT PROBLEMS YOUR CHILD MAY HAVE:

AUTISM

ADD/ADHD

ALLERGIES

ASTHMA

BEDWETTING

COLIC

CHRONIC SINUS

DIGESTIVE ISSUES

DIFFICULTY CONCENTRATING

IRRTIBLE BOWEL SYNDROME

LOW IMMUNE SYSTEM

NIGHT TERRORS

PLAGIOCEPHALY

SPORTS INJURIES

SCOLIOSIS

LATCHING PROBLEMS

CONSTANT FEVERS

WRITTEN CONSENT FOR A CHILD

NAME OF PRACTICE MEMBER WHO IS A MINOR/CHILD

_____

I AUTHORIZE DR. ANDREW NOLT AND ANY AND ALL INSPIRE 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. IF MY AUTHORITY TO SELECT AND AUTHORIZE CARE IS REVOKED OR ALTERED, I WILL IMMEDIATELY NOTIFY INSPIRE CHIROPRACTIC.

_____ _____

Parent / Guardian Signature Date

Date________________

Relationship to Minor____