

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:  Home  Medical  Midwife Duration of Gestation: \_\_\_\_\_ wks  
Was the birth assisted?  Yes  No If Yes, how?  Induction  Forceps  Vacuum  C-section  
Were medications given to the mother during labor?  Yes  No If Yes, what? \_\_\_\_\_

**B. Growth and Development**

Was child alert and responsive within 12 hours of delivery?  Yes  No 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  Smoke  Drink  Take prescription medication  Have chemical exposure

Was your child breastfed?  Yes  No If yes, then for how long? \_\_\_\_\_ weeks  months  years

If no, then at what age was formula introduced? \_\_\_\_\_ Brand? \_\_\_\_\_  
 Milk-based or  Soy-based?

Did your child receive vaccinations?  Yes  No 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?  Yes  No Any problems with bonding?  Yes  No

Does your child have any behavior problems?  Yes  No Describe:  
\_\_\_\_\_

Does your child have difficulties sleeping (e.g. night terrors, sleepwalking, etc)  Yes  No

Describe: \_\_\_\_\_

Did your child go to daycare?  Yes  No From what age? \_\_\_\_\_ Average number of hours of TV/Computer a week \_\_\_\_\_

**E. Traumatic Stressors**

Any evidence of trauma during birth?  Bruises  Odd shaped head  Stuck in the birth canal  Cord around neck

Excessively fast or short birth  Respiratory Depression Other:  
\_\_\_\_\_

Any falls/accidents during pregnancy?  Yes  No Has the child had any major falls, fractures or stitches? \_\_\_\_\_

Any hospitalizations?  Yes  No 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	CHRONIC SINUS	NIGHT TERRORS
ADD/ADHD	DIGESTIVE ISSUES	PLAGIOCEPHALY
ALLERGIES	DIFFICULTY	SPORTS INJURIES
ASTHMA	CONCENTRATING	SCOLIOSIS
BEDWETTING	IRRITABLE BOWEL SYNDROME	LATCHING PROBLEMS
COLIC	LOW IMMUNE SYSTEM	CONSTANT FEVERS

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### **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 \_\_\_\_\_