

## Parent / Child Health Questionnaire

**Note:** Injury to the spine during the birth process, as well as the numerous falls and accidents during childhood, could be the unsuspected cause of many health problems in children.

Name of child: \_\_\_\_\_

Address: \_\_\_\_\_ Postal Code \_\_\_\_\_

Phone Number: \_\_\_\_\_ Sex: Male / Female

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Name of Parent: \_\_\_\_\_

Address (if different from child): \_\_\_\_\_

**Does or did your child suffer any health problems such as:**

(please circle all that apply)

Headaches

Irritability

Diarrhea

Allergies

Hyperactivity

Constipation

Ear problems

Frequent colds

Colic

Sleeping disorders

Flu

Rashes

Breathing problems

Digestive problems

Milk or lactose intolerance

Fatigue

Meningitis

Bed wetting

Other: \_\_\_\_\_

Has your child had any adverse reactions to any vaccinations? If so, please list what vaccination, the age of your child at the time, and what reactions occurred.

\_\_\_\_\_

\_\_\_\_\_

**Regarding your child today:**

(please check those that apply)

Is your child accident prone ? \_\_\_ Has the child had any falls down the steps ? \_\_\_

Has your child ever fallen from heights over 2 feet ? \_\_\_ Has your child ever been involved in a motor vehicle accident ? \_\_\_

Has your child ever been hospitalized or had surgery ? \_\_\_ Has your child had a scoliosis exam ? \_\_\_

Is your child hyperactive ? \_\_\_ Does your child have learning disorders ? \_\_\_

Does your child have sleeping difficulties ? \_\_\_ Poor posture ? \_\_\_

Does your child have any problem associating with friends ? \_\_\_

Is your child nervous, or has anyone suggested that your child was nervous ? \_\_\_

Does your child show any signs of nervousness, twitching, or excessive talking to themselves ? \_\_\_

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

\_\_\_\_\_

Does your child suffer from: Allergies \_\_\_ Asthma \_\_\_ Headaches \_\_\_

Has your child ever had any broken bones or sprain injuries ? \_\_\_

Is your child on any medication ? \_\_\_

**Regarding Pregnancy:**

Were you on medication ? \_\_\_\_\_

Did you smoke or consume any alcoholic beverages ? \_\_\_\_\_

Was there back pain ? \_\_\_\_\_

Approximately how long was labour ? \_\_\_\_\_

Were you physically ill during your pregnancy ? (eg. colds, flu, allergies, German measles, etc. ) If so, what ?

\_\_\_\_\_

**Regarding labour:**

Was it chemically induced ? \_\_\_\_\_

Doctor assisted ? \_\_\_\_\_

Was a C-Section performed ? \_\_\_\_\_

Were forceps used ? \_\_\_\_\_

Did the Doctor have hands on the infant ? \_\_\_\_\_

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

Were you lying down ? \_\_\_\_\_

Was the baby premature ? \_\_\_\_\_

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

**Consent to Treatment**

I, the child's legal parent or guardian, hereby request and consent to the performance of chiropractic adjustments and procedures, including various modes of diagnostic testing, on my child by the doctor of chiropractic name below:

\_\_\_\_\_  
Print Child's Name

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date