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