

Child Chiropractic Health Questionnaire

Name _____ Home Phone _____

Address _____

City, State, Zip _____

Birth date _____ Age _____ Grade _____ Male _____ Female _____

E-mail Address _____

Parent/Guardian _____ Cell Phone _____

Welcome to our office!

It is well known that families who maintain strong healthy, well-aligned spines have much improved health. People whose spines are not kept in proper alignment are much more likely to develop health disorders later in life such as arthritis, illness, pain, heart attacks, strokes, even cancer.

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 _____

Telephone Call Yellow Pages Sign Website Presentation E-mail

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

3. How was your pregnancy with your child? _____

4. 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) YES NO

5. How long was the actual labor and delivery time? _____

6. How many weeks along was your child born? _____

7. What was your child's birth weight _____ and length _____ What was your child's APGAR score? _____

8. Where was your child born? _____

9. Is your child up to date on their vaccinations? YES NO

10. Did your child reach all their milestones on time? YES NO

If no, please elaborate _____

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

12. 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

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

14. Does your child suffer from any of the following: allergies, sinus problems, bed-wetting, difficulty concentrating, attention deficit disorder? (Please circle)

15. Does your child have other health problems that concern you? _____

16. Do you miss work or sleep due to your child's illnesses? YES NO

17. Do you worry often about your child's health? YES NO

18. Are there any health problems that affect your family? Please list _____

19. 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? _____

20. Falls, sports impacts and auto accidents can cause serious spinal problems. Is this visit related to an auto accident or injury?
 YES NO Date of Incident _____

21. If the doctor feels that your child will benefit from chiropractic care are you willing to follow his/her recommendations?
 YES NO

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

Parent/Guardian Signature _____ Date _____

Consent to Treatment of Minor Child

I hereby authorize McCormick Chiropractic Main Line and whomever they may designate as assistants to administer chiropractic care as deemed necessary to my _____ (indicate relationship of child),
_____ (name of child).

Parent/Guardian Signature _____ Date _____

Parent/Guardian Name: _____ Phone: _____ Cell: _____

Name of Parent/Guardian **responsible** for Patient's Account: _____

Address (if different from address of patient): _____

Phone: _____ Cell: _____