CONFIDENTIAL PATIENT INFORMATION (CHILD)

Dear Parent, ***Please read and complete this questionnaire <u>in detail</u>****. Your answers will help us determine if chiropractic can assist your child. If we do not seriously believe your condition will respond satisfactorily, we will not accept his/her case.*

Childs Name: First _________________________MI _____Last _________________________________Age: __________
Address: ____City: _____________________State: ______Zip: ___________
Parent (s)/Guardian(s): ____
Home Phone: _____________________________ Work Phone: ______________________________ DOB: ______________
Occupation: __________________________________ Employer: ____
Siblings Name(s) & Age(s): ____
____
Most patients are referred to our office by a caring family member or friend. Who may we thank for referring you to our office? ____

Insurance Information

If you are insured and wish for us to assist you in submitting your claims, please provide us with your driver's license and insurance card so that we may make a copy and verify your coverage in this office.

ADDRESSING THE ISSUES THAT BROUGHT YOUR CHILD TO THE OFFICE

Briefly describe the chief area of complaint, including the effect it has had on your child's life. ________________________
____
____
Since the problem started, is it … About the same Getting better Getting worse
What makes it worse? ____
Yes, it interferes with: Sleep Walking Sitting Hobbies Play
Does he/she suffer from any condition other than that which you are now consulting us? Yes / No Please explain._________
____
When did this problem first appear? _______________________________Has he/she experienced this in the past? Yes / No
Doctors seen for this problem: Chiropractor(s) ________________________ Medical Doctor(s) _______________________
Has anyone in your family experienced similar problems? Y / N If so, who? _______________________________________

Prescription medications may cause various side effects, hide the severity of health conditions and or hinder the body's ability to heal. What medications is your child currently taking? ____
____
Has your child ever been knocked unconscious? Y / N Explain:____

BODY SIGNALS

Please circle **<u>ALL</u>** symptoms (body signals) your child has ever had, even if they do not seem related to the current problem.

Headaches	Pins and needles in legs	Fainting	Neck pain
Pins and needles in arms	Colds	Back pain	Loss of balance
Dizziness	Buzzing in the ears	Ear Infections	Nervousness
Numbness in fingers	Numbness in toes	Loss of taste	Stomach upset
Fatigue	Depression	Irritability	Tension
Sleeping problems	Neck stiff	Bronchitis	Asthma
Diarrhea	Constipation	Fever	Continence
Cold sweats	Lights bother eyes	Enuresis (Bed wetting)	Heartburn
Mood swings	Allergies	Ulcers	Colic

Poor posture leads to poor health and often indicates a spinal condition.
How would you rate your child's posture? Poor – 1 2 3 4 5 6 7 8 9 10 – Excellent

Patient's/Guardian's Signature: X ____Date: ______________

Family History and Personal History Information

FAMILY HISTORY (If your mom had it put an M, if dad put a D, and if both had it put a B.)

( ) High Blood Pressure ( ) Heart Attack ( ) Emphysema ( ) Asthma ( )Ulcer / Digestive Issues
( ) Diabetes ( ) Kidney Disease ( ) Mental Illness ( ) Cancer
( ) HIV Positive ( ) Thyroid Disease ( ) Circulation Problem
( ) Arthritis /Rheumatoid ( ) Seizures/Convulsions ( ) Stroke (Indicate Age at first stroke Mother ___ Father ___)

ACTIVITIES OF DAILY LIVING

Check each of the activities which you have difficulty performing or causes pain when performing.

General

___ Walking ___ Standing ___ Running ___ Sitting
___ Lifting Children ___ Bending ___ Climbing Stairs ___ Reading
___ Laying in Bed ___ Chewing ___ Swimming ___ Getting in/out of Car
___ Playing Piano ___ Using Computer ___ Kneeling ___ Sexual Intercourse
___ Sports (List:__________) ___ Sleeping ___ Using Telephone ___ Other________________

House and Yard Work

___ Laundry ___ Making Beds ___ Vacuuming ___ Doing Dishes
___ Cooking ___ Carrying Groceries ___ Caring for Pets ___ Shoveling Snow
___ Mowing Lawn ___ Raking Leaves ___ Gardening ___ Other________________________

Personal Grooming

___ Combing Hair ___ Shaving ___ In/Out Bathtub ___ Brush Teeth
___ Dressing Yourself ___ Other: ____________

Travel

___ Driving ___Riding (Passenger) Minutes per Day spent in ____Car ___ Bus or Other:_______

REVIEW OF SYSTEMS (Check ones that you have now or have had in the past.)

Now	Past		Now	Past		Now	Past	
___	___	Seizures	___	___	Vertigo	___	___	Dizziness
___	___	Hand Trembling	___	___	Loss of Sensation	___	___	Incoordination
___	___	Loss of Facial Expression	___	___	Weak Grip	___	___	Paralysis
___	___	Difficulty w/Speech	___	___	Tingling	___	___	Loss of Memory
___	___	Numbness	___	___	Weight Gain	___	___	Weight Loss
___	___	Breast Changes	___	___	Heat Intolerance	___	___	Cold Intolerance
___	___	Hyperventilation	___	___	Insecurity	___	___	Depression
___	___	Troubled Sleep	___	___	Irritable	___	___	Undecidedness
___	___	Timid	___	___	Hallucinations	___	___	Loss of Memory
___	___	Drug Dependency	___	___	Drug Addiction	___	___	Alcoholism
___	___	Suicidal Thoughts	___	___	Extreme Worry	___	___	Sexual Problems
___	___	Muscle Pain	___	___	Muscle Weakness	___	___	Muscle Cramps
___	___	Muscle Twitching	___	___	Joint Stiffness	___	___	Joint Pain

PAST MEDICAL HISTORY (Check ones that you have had in the past.)

___ Hay Fever ___ Mumps ___ Rheumatic Fever ___ Allergies ___ Sexual Problems
___ Cancer ___ Tumor ___ Blood Disease ___ Leukemia ___ Heart Trouble
___ Depression ___ Phlebitis ___ Hypertension ___ Stroke ___ Mental Illness
___ Jaundice ___ Polio ___ Skin Trouble ___ Gallstones ___ Liver Trouble
___ Hepatitis ___ Parasites ___ Epilepsy ___ Paralysis ___ Prostate Problem
___ Alcoholism ___ Dysentery ___ Varicose Veins ___ Diabetes ___ Gout
___ Syphilis ___ Migraine ___ Hemorrhoids ___ Nervous Breakdown ___ Gonorrhea
___ Ulcers ___ Angina ___ Bladder Trouble ___ Kidney Stones ___ Kidney Infections
___ Other________________________

IMMUNIZATIONS (Check ones that you have had in the past.)

___ DPT ___ Mumps ___ Smallpox ___ Typhoid ___ Tetanus ___ Chicken Pox
___ HPV ___ Influenza ___ Polio ___ MMR ___ HPV ___ Pneumococcal
___ Measles ___ Other_________________

Print Name:____ Date:_______________

Signature:____