

Welcome to our office! Please answer the following questions:

Name _____ Home Phone _____
 Address _____ Work Phone _____
 City, State, Zip _____ Cell Phone _____
 E-mail Address _____
 Birth Date _____ Age _____ Grade in School _____

1. Spinal problems can cause a variety of health problems. Please check the health complaint(s) your child is currently experiencing or experiences on a periodic basis:

- | | | | |
|----------------------------------|--------------------------------------|--|---------------------------------------|
| <input type="radio"/> Neck Pain | <input type="radio"/> Asthma | <input type="radio"/> Frequent Colds | <input type="radio"/> Skin Problems |
| <input type="radio"/> Back Pain | <input type="radio"/> Allergies | <input type="radio"/> Spinal Curvature | <input type="radio"/> Chronic Fatigue |
| <input type="radio"/> Headaches | <input type="radio"/> Sinus Problems | <input type="radio"/> Indigestion | <input type="radio"/> ADD/ADHD |
| <input type="radio"/> Bedwetting | <input type="radio"/> Ear Infections | <input type="radio"/> Arthritis | <input type="radio"/> _____ |

2. What is your child's primary health complaint? _____

3. Research shows that spinal problems often begin at birth. How old was your child when they received their first chiropractic checkup?

- Never 0 – 2 years 2 - 5 years 5 – 12 years

4. Difficult, long, and/or doctor-assisted births can cause spinal misalignments. Was your child born vaginally, by C-section, forceps, suction cup, or other device? (Please circle one)

5. How long was the actual labor and delivery time? 0 – 3 hours 3 – 12 hours 12 - 24 hours > 24 hours

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

7. Poor posture can lead to poor health and usually indicates a spinal problem. How would you rate your child's posture?

Poor – 1 2 3 4 5 6 7 8 9 10 – Excellent

8. Did your child have early health challenges such as colic, irritability, or frequent ear infections? YES NO

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

10. Do you miss work or sleep often due to your child's illness(es)? YES NO

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

12. Do you have any health problems that affect your family? Please list _____

13. Is your child currently taking prescription medication? YES NO Please list _____

14. Falls, sports impacts, and auto accidents can cause serious spinal problems. Is this visit related to a fall, sports impact, auto accident or injury? YES NO Date of incident _____

15. 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. Copies of any x-rays and reports will be released upon written request, however original x-rays remain the property of the clinic.

Signature _____ Date _____