BACK TO WELLNESS FAMILY CHIROPRACTIC

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Chiropractor

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CHILD & ADOLESCENT HEALTH QUESTIONNAIRE

Name:_____ Mother's Name:_____

Birth Date:_____ Age: _____ Father's Name: _____

Mailing Address:_____ City: _____

Postal Code:_____ Home Phone:_____ Parent Cell Phone:_____

Name of person who referred you to our office: _____

HEALTH INFORMATION REGARDING THE CHILD

What is the reason for your visit with us today? _____

How long have you had this condition? _____

Have you had this or similar conditions in the past? _____

What makes it feel better? _____

What aggravates your condition? _____

Is this condition getting progressively worse? _____ Have you had x-rays of your spine in the past year? _____

Have you had other doctors treat this condition/who? _____

Tell us what has been done so far that has not worked? _____

Has the child ever suffered from: (check off all that apply)

Dizziness_____	Allergies_____	Diabetes_____	Digestive disorders_____
Heart Trouble_____	Asthma_____	Neck Pain_____	Backaches_____
sinus Trouble_____	Nervousness_____	Headaches_____	

Tell us about Mom's pregnancy:
Did you carry full term?_____ How many previous pregnancies did Mom have?_____

Describe any complications and when they occurred: _____

CHILD & ADOLESCENT HEALTH QUESTIONNAIRE

Name of child:_____

Tell us about the delivery and birth of this child:

Did you use a Midwife?_____ Did you deliver at a hospital?_____ Did you have an Obstetrician?_____
Did you have a C-Section?_____ Were forceps used?_____ Vacuum Extraction?_____
Were you induced?_____ Did you have an Epidural?_____ How long was labour?_____
What was the baby's APGAR score?_____

Tell us more:

Do/Did you breastfeed?_____ If yes, for how long?_____Did you consume alcohol during your pregnancy?_____
Did you smoke?_____
Did you take any medications during your pregnancy?_____For what?_____

_____ What type? _____

How many ultrasounds did you have during pregnancy?_____

Sleeping
Does the child fall asleep in less than 20 minutes?_____ more than 20 minutes?_____
How long does the child sleep at night?_____hours. Naps?_____hours
Does the child cry less than 2 hours per day?_____ Does the child sleep on his/her back or belly or side?_____

Feeding
Does/did the child breastfeed?_____ How long after birth did the child feed/suck?_____hours/minutes
Is feeding messy? Describe the abount of "dribble" during feeding:_____
Is "feeding" enjoyable for the child?_____ Is breastfeeding comfortable for Mom?_____
Would you say this child has a difficulty with sucking?_____

Elimination
How often are bowel movements per day?_____ How often does the child urinate per day?_____
Are bowel movements difficult for the child?_____ Is the child's stool soft or hard or liquid-like?_____
What is the colour of the stool?_____ Is the child gaining weight?_____
Is the child growing?_____ Is the child current with his/her vaccinations?_____

List any medications your child is currently taking: _____

_____

_____

List any allergies: _____

List any allergies of Mom, Dad or siblings: _____

_____

_____

I understand that any insurance coverage besides O.H.I.P. is an arrangement between the insurance company and myself. I understand that *Back to Wellness Family Chiropractic* will prepare any necessary reports and forms to assist me in collection from the insurance company. Furthermore, I understand and agree that all services rendered are charged directly to me and that I am personally responsible for payment.

INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENT AND CARE
Physicians, Chiropractors, Osteopaths and Physiotherapists are required to advise patients with neck problems of the following: There have been very rare incidents of injury to the vertebral artery during the course of treatment. This has caused strokes or stroke-like occurrences, which are usually of a temporary nature. The chances of this happening are less than one in ten million. Tests, with or without x-rays will be performed on you to minimize this risk to yourself. Chiropractic is considered to be one of the safest and most effective terms of therapy for neck conditions. If you have any questions about this, please ask your Chiropractor.

I have read the above statements and consent to treatment.

_____ _____ _____
Print Name Signature of Parent or Guardian Date