Child Patient Questionnaire

Confidential Patient Information

Legal First Name: _____ MI: _____ Legal Last Name: _____

Date of Birth: _____ Sex: M or F Parents Names: _____

Street Address: _____

City, State, Zip Code: _____

Email Address: _____

Phone Number: _____ Type of Phone Number: Cell Home Work

Do you want appointment reminders via Text or Email? Y or N If Y, preferred method? Text Email

Emergency Contact Name: _____ Phone #: _____

Primary Care Physician: _____ Does he/she get well child checkups: Y or N

Any significant family medical history (mom, dad, brothers, sisters, grandmas or grandpas: Y or N

If Y, who and what condition did they have: _____

_____

Current Health Conditions

What concerns(s) bring you into our office? Please list in order of importance.

1. _____ When did symptoms begin? _____

2. _____ When did symptoms begin? _____

Have you had issues in any of these areas prior to today's visit? Y or N

If Y, Condition number (from above) and when have you experienced the same issues in the past?

_____

Was this condition caused by a work accident or motor vehicle accident? Y or N

What makes the condition feel better? _____

What makes the condition feel worse? _____

Are there specific activities that this condition keeps him/her from doing? _____

Is there ANY chance that he/she could be pregnant? Y or N If Y - Due Date: _____

Past Health History

Has he/she seen a chiropractor in the past? Y or N If Y, who and how recent? _____

Has he/she been treated using the chiropractor hands or using a tool? _____

Has he/she ever had any previous accidents, slips, or falls resulting in injury? Please include type of accident, year, and any injuries received in the accident.

1. _____

2. _____

How often does he/she exercise? Not at all 1-3 day per week 4-6 days per week Daily Play activities only

Type of exercise you do? _____

What position does he/she typically sleep in? On my Stomach On my Side On my Back

Does he/she follow any special diets? _____

Please list all diagnosed conditions: _____

History of cancers, seizures, strokes, high blood pressure, diabetes? _____

Current medications: _____

Had any recent x-rays, CT scans, MRIs or other imaging? If Y list where and what was performed.

_____

Surgeries (Place an X in the box if you have had any surgery in these areas)

[ ] Appendix	[ ] Obstetrical	[ ] Foot	[ ] Shoulder
[ ] Brain	[ ] Elbow	[ ] Back	[ ] Gallbladder
[ ] Hernia	[ ] Gastrointestinal	[ ] EENT	[ ] Wisdom teeth
[ ] Heart	[ ] Gynecological	[ ] Other_____	
[ ] **None of the above**			

Medical History (Place an X in the box if you have or have had in the past any condition listed)

[ ] Arthritis	[ ] Asthma	[ ] Back pain	[ ] Broken bones
[ ] Cancer	[ ] Chest pain	[ ] Anxiety/Depression	[ ] Diabetes
[ ] Dizziness	[ ] Epilepsy	[ ] Eye/vision trouble	[ ] Fainting
[ ] Fatigue	[ ] Genetic spinal disorder	[ ] Headaches	[ ] Hearing trouble
[ ] Heart attack	[ ] Hepatitis	[ ] High blood pressure	[ ] Jaw pain
[ ] Joint stiffness	[ ] Low back pain	[ ] Menstrual problems	[ ] Multiple Sclerosis
[ ] Neck pain	[ ] Neurological disorder	[ ] Pacemaker	[ ] Parkinson's Disease
[ ] Prostate problems	[ ] Significant weight change	[ ] Sleep Apnea	[ ] Spinal cord inj.
[ ] Sprain/strain	[ ] Stomach problems	[ ] Stroke	[ ] Tumor
[ ] Ulcer(s)	[ ] Other_____		[ ] **None of the above**

Acknowledgement & Consent

I, the undersigned, acknowledge that all of the above statements in this form are true to the best of my knowledge. I hereby authorize the doctor to examine and treat my condition as he/she deems appropriate through the use of chiropractic care, and I give authority for these procedures to be performed.

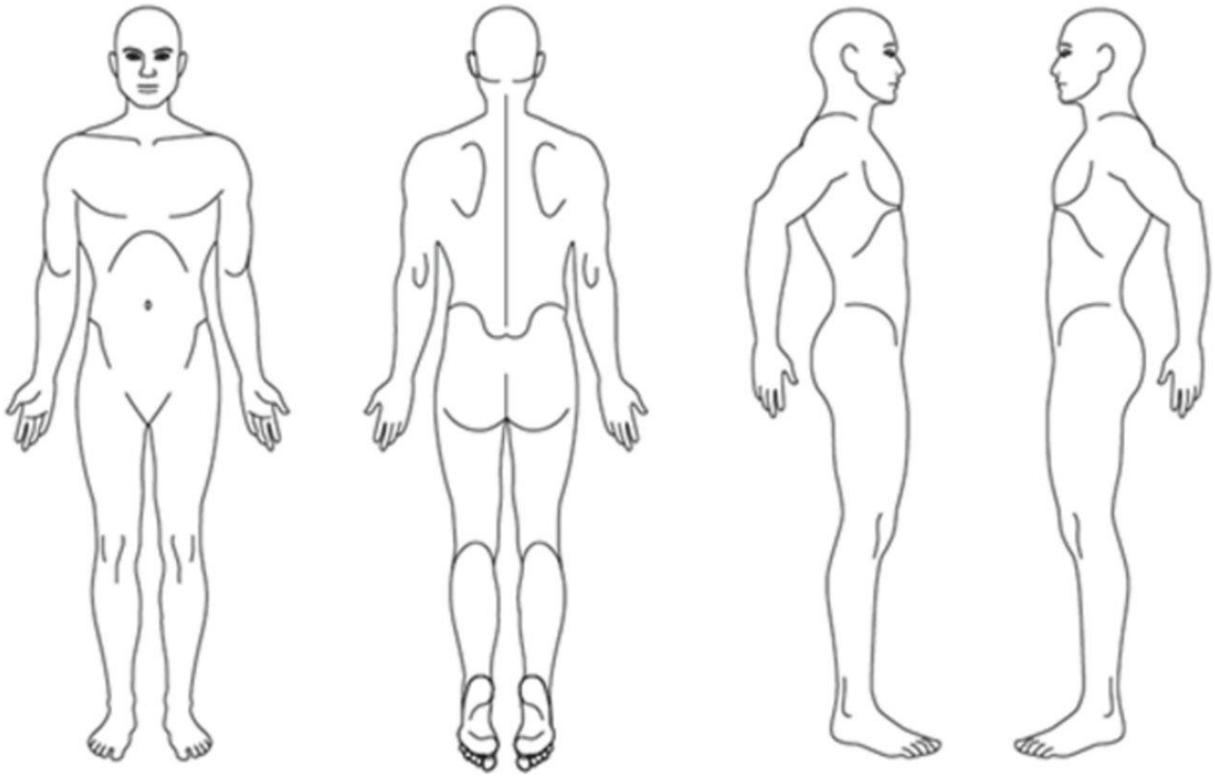
Patient's Parent or Legal Guardian Signature _____ **Date:** _____

Pain Drawing

Name: _____ Date: _____

Use the following descriptive symbols on the image below to show the type of discomfort you are feeling and draw on the image as to where you are having the symptoms.

Aches	Numbness	Burning	Stabbing	Pins & Needles	Stiffness	Other
^^^	ooo	xxx	///	…..	+++	- - -



Indicate on the line how severe your pain is by marking an "X" on the line

(0 = no pain, 1-4 is mild, 5-7 is moderate, 8-10 is severe)

Rate your neck pain. 0 _____ 10

Rate you back pain. 0 _____ 10

Rate your arm pain. 0 _____ 10

Rate your leg pain. 0 _____ 10