Chiropractic Advantage

CHILD HEALTH QUESTIONNAIRE

(to be filled out by parent)

Child First Name _____ **MI** _____ **Last Name** _____ **Gender** M F

Date of Birth _____ **Social Security #** _____ **Race** _____

Cell Phone _____ **Home Phone** _____ **Work** _____

Address _____ **City** _____ **State** _____ **Zip** _____

Emergency Contact _____ **Relationship** _____ **Phone** _____

Whom may we thank for referring you? _____ **Relationship** _____

Parent's Names _____ **Primary Email** _____

I, _____ **understand that I am personally responsible for payment at the time services are rendered**

Signature _____ **Date** _____

PRIMARY CONCERN

What is your child's **primary** health problem? _____

_____

Date of original problem: _____ Date of most recent recurrence: _____

Was there an event that created the problem? _____

Has your child had this or similar conditions in the past? _____ Is the problem worsening? _____

What makes it better? _____ Worse? _____

Is the problem interfering with school? _____ Sleep? _____ Activity? _____ Other?_____

What can your child not do now that she/he would like to do? _____

What do you believe is wrong with your child? _____

_____

What are your goals for treatment? _____

HEALTH HISTORY

List all other **CURRENT** problems **in their order of importance** _____

_____

_____

_____

Please check and describe the following:

Vaginal Birth? Y / N Duration: _____

C-section? Y / N If Yes, why?_____

Check and describe when necessary all that apply:

☐Forceps ☐Vacuum ☐Extraction ☐Home Birth ☐Hospital ☐Birthing Center ☐Induced
☐Fast Birth ☐Prolonged ☐Spontaneous ☐Induced ☐Full-term ☐Premature _____

Delivery complications: _____

Did your child suffer with colic, reflux, other? Y / N

If yes describe_____

List other practitioners seen, treatments, self care activities, and results _____

_____

_____

_____

_____

Does your child have any spinal abnormalities that you are aware of? _____

List **ALL** significant PAST illnesses _____

_____

_____

Please list **ALL** surgeries your child has had, with dates and results _____

_____

Has your child ever been hospitalized other than for surgery? _____

Has your child ever been in an accident (significant fall/trauma) or seriously injured? List dates and

describe _____

_____

Describe your child's worst injury ever, and any long lasting effects it has had on his/her health _____

_____

Describe any travel related illnesses _____

How many doses of antibiotics has your child had in his/her lifetime?_____ Reason? _____

Is there a time in your life when your child began feeling significantly less healthy? Y / N

If yes, describe. _____

How many **times/month** does your child take aspirin?____ Ibuprofen?____ Tylenol?____ Antacids?_____ Laxatives?___

For what purpose are these taken? _____

List all medications your child is currently taking and why. _____

_____

List all medications your child has taken in the past and why _____

_____

FAMILY HISTORY

Have any of your child's blood relatives (parents, brothers, sisters, aunts, uncles, grandparents, or children), living or deceased, had any of the following problems? **For each YES**, state the age of the person when the problem occurred and their relationship with your child.

Condition	Yes	No	Age	Relationship
Alcoholism/Drug Addiction	☐	☐		
Allergies/Asthma	◯	☐		
Arthritis	☐	☐		
Blood Disorders	☐	☐		
Cancer	☐	☐		
Diabetes	☐	☐		
Digestive Disorders	☐	☐		
Heart attack before age 55	☐	☐		
Heart attack after age 55	☐	☐		
High blood pressure	☐	☐		

Have any of your child's blood relatives (parents, brothers, sisters, aunts, uncles, grandparents, or children), living or deceased, had any of the following problems? **For each YES**, state the age of the person when the problem occurred and their relationship with your child.	Y	N	AGE	
Kidney or Liver disease	☐	☐		
Lung disease/tuberculosis	☐	☐		
Mental health problems/depression	☐	☐		
Seizure Disorder	☐	☐		
Stroke	☐	☐		
Thyroid Disease	☐	☐		
Uterine/Ovarian problems	☐	☐		

List other problems that run in your family _____

NUTRITION

Was your child breastfed? Y / N If Yes, How long? _____

If not - Why? _____ Supplemental Formula _____

What does your child usually eat and drink on a **typical weekday**?

Breakfast _____

Morning snack _____

Lunch _____

Afternoon snack _____

Dinner _____

Evening snack _____

Desserts _____

How many glasses of water per day? _____ Coffee _____ Tea _____ Soda _____ Juice _____

How many meals each week are:

At home _____ Alone _____ In restaurant _____ At fast food place _____ TV Dinners or "convenience" food _____ While at play _____ While watching TV _____ From deli _____ At health food restaurant/take out_____

Does your child enjoy eating cheese? Y / N Drinking milk? Y / N If so, how much per day? _____

Does your child like sweets, pastries, cakes, donuts, etc? Y / N How many servings per day _____

Does your child eat artificial sweeteners in foods/diet soda? Y / N How many servings per day? _____

Does your child eat sugarcoated cereal or add sugar to cereal? Y / N How many times per day? _____

What is your child's preferred snack food?_____

Is there one food that your child likes the most, and craves when you they don't have it?_____

How many servings of vegetables per day? _____ Child does not eat any vegetables? Y / N

List the three healthiest foods your child eats in an average week: _____

List the three unhealthiest foods your child eats in an average week: _____

Are there particular foods that irritate your child in any way? Y / N If yes, name the foods and describe the problem: _____

Please describe any ways in which you feel your child's diet is **excessive**: _____

_____

Please describe any ways in which you feel your child's diet is **deficient**: _____

_____

List all **vitamins and other supplements** your child is now taking _____

_____

_____

HABITS

Describe your child's exercise habits (activity/times per week) _____

Describe your child's current sleeping pattern (bedtime, wake up, napping, difficulty with sleep) _____

Does your child have enough energy for your normal activities? Y / N

How long does your child watch TV each day? _____

How long does your child play video games/ipad/phones etc? _____

What does your child do for fun/pleasure/relaxation? _____

PREVENTIVE MEASURES AND SCREENING

When (month/year) did your child last receive the following (leave blank if it does not apply).
Mark with an A if abnormal result

physical	blood test	rectal exam	bone density
colonscopy	skin exam	TB skin test	Chest x-ray
dental exam	eye exam	hearing test	pap smear
mammogram	other tests		

Has your child ever had an MRI, X-ray or CT scan? Y / N If so, what for? _____

Is your child up to date on all vaccines? Y / N

ALLERGIES AND SENSITIVITIES

Please list any allergies you are aware of (foods/medications/other): _____

Please list any chemical sensitivities you are aware of: (bleach, solvents, perfumes, etc.) _____

Is your child particularly sensitive to the effects of medications? Y / N

Has your child ever reacted to a medication in an unexpected way? Y / N

If yes, please describe _____

Has your child had problems with damp or moldy places? Y / N Problems with new building materials? Y / N

MEDICATIONS

The treatment that the Doctors provide is intended to improve all aspects of your child's health. As your child's care progresses, his/her body may be better able to heal itself in all respects. Because of this, your child's cognitive functions, allergic responses, blood sugar levels, and other important bodily functions may improve. If this occurs, it is possible that the doses of medications your child is now taking will have to be modified, to account for this improvement. It is your responsibility to monitor or have monitored those of your child's functions that relate to medications he or she is currently taking, to ensure that your current dose does not become excessive or deficient in its effect on your child. These and any other changes to your regimen of medications must be made in coordination with and under the instructions of the physician who prescribed them.

ADDITIONAL INFORMATION

Please arrange to have any other relevant information sent to our office. This might include medical records, lab results, consultation reports, and any other test or study results such as x-rays or CT scans. This will help the doctors evaluate your condition. Short documents like lab results or MRI reports may be faxed to (919) 759-9177. Longer documents like overall patient records should be copied and sent to the office at 206 East Mulberry Street, Goldsboro NC 27530.

Please list your child's pediatrician and other doctors, so we can send a report to them with the details of your child's case, should it become appropriate to do so. List each doctor's full name and as much of the address information as you know.

_____ _____

_____ _____

_____ _____

_____ _____

Patient Care Services.
We require that charges on the date of service be paid in full, except If you have a documented worker's compensation case or motor vehicle accident (please notify staff immediately) with all appropriate forms and liens signed. We do reserve the right to charge 1.5 percent monthly interest on all account balances over 60 days.

Our Policy on Health Insurance.
Today most policies do cover alternative health care however there is a large number that have copays that are much greater than our fees, therefore we will not submit those claims. We cannot take responsibility for what your health insurance will or will not cover.

Appointments.
In order to better serve our patients, we ask that you call in advance if you are unable to make your appointment, or if you will be late (we will do our best to accommodate you). Your appointment time is reserved especially for you. If you fail to notify our office within 24 hours of cancellation, this may lead to a missed appointment fee. If you are unable to make your massage appointment and it is less than 24 hours advanced notice, your credit card on file will be charged in full for the service scheduled.

Questions and Answers.
Please feel free to ask any available staff member questions regarding your account. We will make every effort to answer your inquiries.
I have read and understand the office policy and to the best of my knowledge the detailed information I have provided is accurate.

Signature _____ **Date** _____

Relationship to the patient _____