Park County Chiropractic ~ Childrens Questionnaire

Please Print. Fill out completely as these questions will assist the doctor in the treatment of this child.

Childs Name___________________________________ Parent's Names:____

Date:_____________________ Date of Birth:__________________________ Approximate Weight:________________

Address________________________________ City/Zip________________________ Guardian Phone#_______________

What medication/vitamins taken?____

Was the child premature? ☐Yes ☐No If Yes, ____________weeks Was the child breech? ☐Yes ☐No

Was the child delivered ☐C-Section or ☐Vaginal? Was there any birth trauma? ☐Yes ☐No

If Yes, explain____

When did the child start to crawl?_____________________ Did the child scoot or crawl on all fours?________________

When did the child start to walk?______________________ Any difficulties in coordination? ☐Yes ☐No

Has the child had any injuries or trauma since birth? ____

____

Did the child nurse? ☐Yes ☐No If Yes, was there any trouble nursing? ☐Yes ☐No

If Yes, explain____

Does the child have any Foods Allergies ☐Gluten ☐Dairy ☐Tree Nuts ☐Peanuts ☐Eggs
☐Soy ☐Orange/Citrus ☐Other______________________________

Does the child cry easily? ☐Yes ☐No How long does the child sleep through the night? ________________ Hours

Does the child have any difficulties with school?____

Does the child have any learning difficulties?____

What do teachers/other caretaker say about him/her?____

Does the child have any difficulties with: ☐Speech ☐Hearing ☐Sight ☐Walking ☐Social Activities

☐Wetting the Bed ☐Anger ☐Homesick ☐Fears____

Please write down any particularities or important information about your child ___________________________________

____

____

What do you expect with care in this office? ____

HABITS

Diet: Does the child crave salt? ☐ *Yes* ☐ *No* ☐ *Sometimes* Does the child eat butter? ☐ *Yes* ☐ *No*

Does the child have any particular food cravings____

Sleep: ☐ Difficulty falling asleep ☐ Difficulty staying asleep ☐ Daytime Sleepiness Other____________________

Exercise routine: Play Sports –please list?____

How often does the child participate in above listed sports? ☐ daily ☐ 5 days/week ☐ 3 days/week ☐ weekly

How often does the child participate in active play? ☐ 1 hour daily ☐ 30 mins daily ☐ 4 hours weekly

How many hours per day does the child participate in inactive play? ☐ 1 hour daily ☐ 30 mins daily ☐ 4 hours weekly

Drink: Coffee, cups daily ☐ 1 ☐ 2 ☐ 3 Juice ☐ 1 ☐ 2 ☐ 3 ☐ 4 Soda ☐ 1 ☐ 2 ☐ 3 ☐ 4

Water Intake, cups daily ☐ 1 ☐ 2 ☐ 3 ☐ 4 Sports/Flavored waters ☐ 1 ☐ 2 ☐ 3 ☐ 4

Behaviors: Does the child Chew on Ice ☐ *Yes* ☐ *No* Fingernails ☐ *Yes* ☐ *No* Eat dirt ☐ *Yes* ☐ *No*

HISTORY – SAS THE CHILD HAD IN PASS OR HAVE CURRENTLY?

☐ Ringing in Ear(s)
☐ Ear Infections Frequent
☐ Dizzy/Fainting
☐ Failing Vision
☐ Eye Infections
☐ Nose Bleeds
☐ Sinus Trouble
☐ Sore Throats Frequent
☐ Hayfever/Allergies
☐ Pneumonia
☐ Bronchitis/Chronic Cough
☐ Asthma/Wheezing
☐ Heart Murmur
☐ Leg Pain – Walking
☐ Fatigue
☐ Loss of Appetite
☐ Weight Loss – Recent
☐ Abnormal Weight Gain
☐ Difficulty Swallowing
☐ Persistent Nausea/Vomiting
☐ Abdominal Pain

☐ Change in Bowel Habit
☐ Diarrhea
☐ Constipation
☐ Urine Infections Frequent
Urination ☐ More than twice per night ☐ Painful ☐ Loss of Control

☐ Anemia
☐ Bruise Easily
☐ Bleeding Gums
☐ Cancer __________________
☐ Diabetes _________________
☐ Thyroid Disease ____________
☐ Convulsions/Seizures
☐ Lactose Intolerance
☐ Phobias
☐ Moodiness – Excessive
☐ Nervousness
☐ Depression
☐ Mental Illness
☐ Memory Loss

☐ Muscle Weakness
☐ Numbness/Tingling Sensation
☐ Back Pain - Recurrent
☐ Headaches Frequent
☐ Bone Fracture/Joint Injury
☐ Foot Pain
☐ Toes Point Inward
☐ Frequent Infections
☐ Rashes/Hives Frequent
☐ Dry Skin
☐ Psoriasis
☐ Eczema
☐ Acne
☐ Hyperactive
☐ Easily Startled/Frightened
☐ Cold/Canker Sores

Has the child had:

☐ Herpes ☐ Tuberculosis ☐ Other_______________
☐ Diphtheria ☐ Tetanus ☐ Chicken Pox
☐ Polio ☐ Mumps ☐ Measles
☐ Rubella ☐ Scarlet Fever ☐ Rheumatic fever

Who is Responsible for the bill: You and ☐ Spouse/Other Parent ☐ Other _________________________________

As a service to you, we will send insurance claims for services for you. You are responsible to pay the amount due at each visit and your insurance will reimburse you directly. Would you like claims sent to:

☐ Health Insurance ☐ Auto Insurance ☐ Other____

Please bring your child's insurance information to the front desk.

I clearly understand and agree all services rendered my child are charged directly to me and that *I am personally responsible for payment*. I also understand that if I suspend or terminate treatment, fees for professional services rendered my child will be immediately due and payable. All information gathered by Park County Chiropractic is kept confidential. If you have any questions regarding our privacy policy, feel free to ask. If you would like a copy of records, a release form must be signed before any records can be discharged.

Parent/Guardian Signature ____ Date _____________________