HEALTH QUESTIONNAIRE - CHILD (1-12 yrs) **File # ______**

This is a comprehensive questionnaire that is designed for children. You may find some questions irrelevant if your child is older, but please do answer to the best of your ability. Many thanks.

Patient Information:

Name: ____ Age:_______DOB:_____/_____/_____

Sex: __________ Height: __________ Weight: __________

Address:________________________________Suburb:_______________________ Postcode:_______

Mother's Name:___________________ Mobile #: _________________ Email: ______________________

Father's Name: ___________________ Mobile #: _________________ Email: ______________________

Medical Doctor's Name:______________________ Practice address:_____________________________

Siblings Names and Ages:_______________________________________ Name of health fund:________

How did you hear about the clinic? Friend __________________/ Internet / Other ______________________

Please circle the purpose(s) for your child's visit:

Crisis management	Early detection	Prevention	Wellness
Maximizing normal growth & development		Improve immune function	
Other: ***(explain reason of visit)***			

General and Present Health History & Concerns:

What are your concerns about your child's health?____

When did this begin? ___________________ How often do they have these symptoms? ______________

Has this occurred before? **yes / no** When?______________ How often?___________________________

What do you believe is the cause?____

Are your child's symptoms: **getting better, staying the same or getting worse**? (please circle)

What previous treatment has your child received for this condition, by whom and what were the results of that treatment? ____

Has your child been to a Chiropractor before? **yes / no**

What were the reasons for care? _______________________________ Date of last treatment:__________

How would you describe the care they received? **Poor Fair Good Excellent** *(please circle)*

Is your child accident prone? **yes / no**

Describe any significant falls or accidents your child has had: _________________________________

Has your child ever been involved in a motor vehicle accident? _________________________________

Taking any medications? If so, what and what for? ____

Has your child been vaccinated? **yes / no**

How many times has your child taken antibiotics in the last 6 months?__________Lifetime?______________

Has your child been hospitalized or required any surgery, if so when and what for?

____

Was/is your child breast fed? **Yes No** If so, for how long? ______________________

Was/is your child formula fed? **Yes No** If so, for how long? ______________________

Does/did your child suffer from colic? **Yes No** If so… **Mild Mod Severe**

Does/did your child suffer from reflux? **Yes** **No** If so… **Mild** **Mod** **Severe**

Often seemingly unrelated symptoms can manifest as other health concerns. Please circle if your child has had any of the following:

Headaches	Chest pressure	Weight loss	dizziness
Chest pain	Weight gain	Irritability	Frequent colds
Dental problems	Fatigue	Sinus congestion	fevers
Depression	Sore throats	Heart palpitations	Loss of balance
Ear pain/infections	Numbness in feet	Loss of concentration	Asthma
Numbness in hands	Fainting	Cold sweats	Weakness
Ears buzzing	Bronchitis	Heartburn	Poor coordination
Pneumonia	Muscle cramps	Vision changes	Difficulty breathing
Upper back pain	Loss of memory	Allergies	Short of breath
Loss of smell	Neck pain	Low back pain	Constipation
Radiating pain	Light sensitivity	Diarrhea	Sleeping problems
Flush face	Urinary problems	Numbness in legs	Reduced mobility
Bloating/gas	Stiffness	Migraine	Bedwetting
Loss of taste	Reflux	PDD/ Autism	Stomach ache
Scoliosis	Hyperactivity	Poor posture	Growing pains
Seizures	Other:		

Birth History

What was the child's gestational age at birth? _____________weeks

Was your child's birth: **at home, in a birthing centre, hospital, other:___________** (please circle)

Was labour: **spontaneous***,* **induced** (please circle)

Was your child born: **cephalic** *(head first),* **breech** *(feet first)* (please circle)

Describe the birth of your child by circling the relevant items:

Term	Premature	Overdue
Vaginal	Caesarean	Breech
Anterior	Posterior	Suction/Vacuum
Induced	Forceps	

Any other relevant information:____

How long were you in labour for? ___________________ How long did you push for? _______________

Birth weight? __________ What were your child's APGAR scores? @birth:___/10 @5mins:___/10

Was the birth traumatic for your child? ______________ Delivery complications? ______________________

Was your child's head misshapen at birth? ____

Growth & Development History:

Was your child alert and responsive within 12 hours of their birth? **yes / no / unsure**

If no, please explain:____

Does your child sleep: front / back / side (please circle)

At roughly what age did your child:

Respond to sound __________ Follow an object __________ Hold up head __________

Vocalize ________ Sit alone _________ Teethe __________ Crawl __________ Walk ________

Do you consider your child's sleeping pattern normal? **yes / no** How many hours do they sleep per day?___

If no, please explain:____

Family Health History:

Please note any health problems (ie. cancer, hereditary conditions, diabetes, heart disease) that are present in:

Mothers family:____

Fathers family:____

Siblings:____

Physical Stressors:

Since problems that chiropractors look for an detect can be related to many types of stressors, the following information is also very important to me.

Any traumas to the mother during pregnancy? (ie. falls, accidents etc) **yes / no**

If yes, please explain:____

Any evidence of birth trauma to the infant:

bruising | odd shaped head | stuck in birth canal

fast or excessively long birth | respiratory depression | cord around neck

Any significant falls from couches, beds, change tables etc? **yes / no**

If yes, please explain:____

Any significant traumas resulting in bruises, cuts, stitches or fractures? **yes / no**

If yes, please explain:____

Any hospitalizations or surgeries? **yes / no**

If yes, please explain:____

Any sports played?____

Is a school backpack used? **yes / no**

Chemical Stressors

Food/juice intolerance? **yes / no** Type:____

Is your child on or has taken any medications?____

During the mother's pregnancy:

Did the mother smoke? **yes / no** How much?_______________________________________

Drink alcohol? **yes / no** How much?_______________________________________

Any illnesses during the pregnancy? **yes / no** If yes, please describe:_______________________________

Any supplements taken during pregnancy? **yes / no** If yes, please describe:___________________________

Any drugs taken during pregnancy? **yes / no** ____

Any pets at home? **yes / no** type:_________________________________

Any smokers in the home? **yes / no**

Is the diet organic? **yes / no**

Do you use 'green products' in your home for cleaning? **yes / no**

How often do they receive processed foods, white sugar, gluten (flour), dairy in their diet?

never on weekends few times per week daily

each meal special occasions

Are you aware of the impact of nutrition on children's behaviour? **yes / no**

Would you like more information on nutrition for your child? **yes / no**

Psychosocial Stressors

Any problems with bonding? **yes / no** ____

Any behavioural problems? **yes / no** ____

Any inattention? **yes / no** ____

Any hyperactivity or restlessness? **yes / no** ____

Any compulsiveness? **yes / no**

Any difficulties at daycare or school? **yes / no** ____

Any challenges with learning deficiencies? **yes / no** ____

Any night terrors, sleep walking, difficulty sleeping? **yes / no** ____

Any prolonged temper tantrums or separation anxiety? **yes / no** ______________________________________

Is your child in daycare? **yes / no** ____

Average number of hours of TV watched per week:__________

Average number of hours of video games per week:__________

Does your child have a mobile phone? **yes / no** How often do they text or use the phone?_______________

Do you feel that your child's social and emotional development is normal for their age? **yes / no**

Thank you for taking the time in completing this form. If there are any other questions or concerns which you have, please discuss with the chiropractor.

Acknowledgement of Office Policy & Consent:

By signing below you acknowledge consent for a history & physical examination of your child by any of the chiropractic practitioners at Chelsea Chiropractic & Wellness. At any point verbal withdrawal of consent is permitted. A further consent form will be provided for information about any treatment required.

Signature (parent/guardian):_______________________________

Print Name: ____

Date: ____