



Child - Adolescent Health Questionnaire (4 – 15)

Child – Adolescent Information.

First Name: _____ Last Name: _____
Address: _____
City: _____ Province: _____ Postal Code: _____
Date of Birth: D _____ M _____ Y _____ Age: _____
Gender: Female Male
Family Physician _____ Date of last visit: _____
Pediatrician: _____ Date of last visit: _____
Health Card Number: _____

Parent/Guardian Contact Information

Parent/ Guardian Name: _____
Phone Number: _____
Email Address: _____
How did you hear about our office: Website Internet Drive by Referral: _____

Chiropractic Experience

Has your child ever been to a chiropractor before? Yes No
If yes, Name _____ Where _____
Reason for visit: _____ Approximated date of last visit: _____
Was your child adjusted: No Yes

Medication

Number of doses of antibiotics child has taken:
During the last 6 months: _____
Total during lifetime: None 1-5 6-10 More
Number of doses of other prescribed medications child has taken during his/her lifetime:
 None 1-5 6-10 More than 10
Please list all medications: _____

Current Health Condition

Describe the reason for your child's visit: Spinal evaluation Specific health condition Wellness/Prevention

Early detection Maximizing growth and development. Other _____

Describe the specific health condition: _____

When did this condition begin? _____ Suddenly or Gradually

Has this condition occurred before: No Yes When? _____

Does this condition radiate: No Yes

If yes, where? _____

What makes it worse? _____

What makes it better? _____

Does this condition interfere with your child's: Sleep Eating Daily Routine

Is this condition getting worse: No Yes

What other professionals have you consulted for this condition? _____

Treatment received: _____ Results: Good Fair Poor

Recent Medical Tests done (list dates beside)

Blood work _____ Urine Analysis _____ X-rays _____ Other _____

Child's Health History

Please check each of the diseases or conditions that your child has now or has had in the past.

- | | | | | |
|--|--|---|---|--|
| <input type="checkbox"/> Vision changes | <input type="checkbox"/> Headaches | <input type="checkbox"/> Frequent Colds | <input type="checkbox"/> Allergies | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Sleeping problems | <input type="checkbox"/> Bed wetting | <input type="checkbox"/> Colic | <input type="checkbox"/> Irritability | <input type="checkbox"/> Skin problems |
| <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> Urinary problems | <input type="checkbox"/> Digestive problems | <input type="checkbox"/> Bloating/Gas | <input type="checkbox"/> Loss of concentration |
| <input type="checkbox"/> Ear pain/infections | <input type="checkbox"/> Frequent crying | <input type="checkbox"/> Sore throat | <input type="checkbox"/> Breathing problems | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Loss of balance | <input type="checkbox"/> Upper back pain | <input type="checkbox"/> Poor coordination | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Seizure | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Lower back pain |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Leg/growing pains | <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Depression | |
| <input type="checkbox"/> Other _____ | | | | |

Developmental History

Any interventions at birth? Forceps Vacuum extractor C-section Induced labor Epidural

Any evidence of trauma at birth? Bruising Odd shape head Stuck in birth canal Respiratory problems Cord around neck

Has your child fallen from bed, changed table, couch, stairs? No Yes

If yes, explain: _____

Has your child ever been involved in a car accident? No Yes

Describe: _____

Has your child ever been hospitalized? No Yes

Describe: _____

Has your child ever been seen on an emergency basis? No Yes

Describe: _____

Did your child ever have major surgery? No Yes

Describe: _____

Lifestyle /Wellness

How is your child's overall nutrition? Poor Good Excellent

Do you have any nutritional concerns for your child? No Yes

If yes, what are your concerns? _____

Any food and/or milk intolerances/allergies? No Yes

If yes, please describe _____

How often does your child exercise? Daily 2 to 4 times per week Infrequently Never

Does your child participate in any organized sports or physical activities? No Yes

If yes, what are they? _____

How many hours approximately per day does your child spend on electronic devices?

Cell phone: _____ hrs/day Tablet/computer: _____ hrs/day Video games: _____ hrs/day

Do you have any concerns about your child's posture? No Yes

If yes, please describe _____

How would you describe your child's stress level: Low Moderate High

INFORMED CONSENT TO CHIROPRACTIC CARE FOR A MINOR

I hereby request and consent to the performance of chiropractic examination, adjustment, and other chiropractic procedures, including various modes of physical therapy and if necessary, diagnostic x-rays, on my child by the Doctor of Chiropractic and/or anyone working in this clinic authorized by the Doctor of Chiropractic.

I have had an opportunity to discuss with the Doctor of Chiropractic and/or with other office or clinic personnel, the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I further understand and am informed that, as in all health care, in the practice of chiropractic there are some very slight risks to treatment, including, but not limited to, muscle strains and sprains, disc injuries, and strokes. I do not expect the doctor to be able to anticipate and explain all risks and complications and I wish to rely on the doctor to exercise judgement during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interest.

I have read the above and I have had an opportunity to ask questions about its content. By signing below, I agree to the above name procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Name of child receiving care

Parent or guardian authorizing care