Dr. Dustin Morton
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CHILD'S INITIAL QUESTIONNAIRE

Today's Date _____

(to be completed by parent)

Name of Child_____ Middle Initial_____ Sex ☐ Female ☐ Male

Address_____ Birth date_____

City/State_____ Zip_____ Age_____

Home Phone_____ Social Security#_____

Parent's Names_____ _____

E-mail Address_____

May we send your family our weekly Health Tip via email? ☐ Yes ☐ No

Does this child have brothers/sisters? ☐ Yes ☐ No Names_____

Who may we thank for the referral of your child to our office?_____

Does your child have any current health conditions or health challenges? _____

_____

WHAT ARE YOUR OBJECTIVES FOR YOUR CHILD IN CONSULTING OUR OFFICE?

_____

1. Has/Is your child currently benefiting from chiropractic care? ☐ Yes ☐ No
   Who/When was last adjustment?_____

2. Your child's birth process (circle one)

   Birthplace: Home Hospital Birthing Center
   Type: Vaginal C-Section
   Procedures: Forceps Vacuum Extraction

3. Which contact sports does your child participate in?

   Soccer Football Gymnastics Karate Hockey Basketball Dance

   Baseball/Softball Skateboarding Other_____

4. According to the National Safety Council, approximately 50% of infants fall head first from a high place (bed, changing table, etc.) during their first year of life. Has this happened to your child?

   ☐ Yes ☐ No

5. Circle any of the following conditions your child has suffered from during the past six months:

☐ Ear Infections	☐ Scoliosis	☐ Seizures	☐ Chronic colds
☐ Headaches	☐ Asthma/Allergies	☐ Digestive Problems	☐ ADHD
☐ Recurring Fevers	☐ Growing/Back Pains	☐ Colic	☐ Bed Wetting
☐ Car Accident	☐ Temper Tantrums	☐Other_____	

6. How many prescriptions of antibiotics has your child taken:

During the past 6 months ___ Total During His/Her Lifetime ___

7. How many other prescription medications has your child taken:

During the past 6 months ___ Total During His/Her Lifetime ___

8. Did your child have childhood immunizations/vaccinations? ☐ Yes ☐ No

9. Has your child had any surgeries? ☐ Yes ☐ No Describe:_____

Is your child covered by health insurance coverage? ☐Yes ☐No

If you want your insurance company billed, please provide your card for a photocopy.

Consent To Chiropractic Care Of A Minor Child

I hereby authorize Dustin Morton D.C. and whomever he may designate as his assistants to examine and administer chiropractic care as he so deems necessary to my son/daughter,

(Child's name) _____

Dated in Vicksburg, MI on this ____ day of _____ 20____

Parent/Guardian Signature: _____ Witness:_____