LIFEForce Chiropractic

Patient questionnaire for preschoolers age 2 - 6 year olds

Dear parents, the following questions are regarding your child and his/her health history. Your answers to these questions will help us determine and analyze the root cause of their health challenge. In order for us to give the exceptional care you expect for your child, please take your time in answering these questions and be as specific as you can.

Name of your child Date of Birth

Parents Name Best number to be reached

Parents address Email address

1. How can we be of service to you and your child? Prevention or symptoms?

On the following page, please mark the areas on your child's body that hurts, with a mark or an X:

Dr. Gray's comments:

2. What are your child's symptoms and how long have they been there?

3. Have you seen another provider for this? If yes, who was the provider and how often were you seen?

4. Who is your pediatrician?

Pregnancy / Birth

5. Was this your first pregnancy? If not, how many siblings are there and what are their ages?

6. Which week of pregnancy did your child arrive?

7. Did you have a vaginal birth or a C-Section?

8. How was the health of your baby directly after the birth?

9. How old were you when you had your baby?

Infancy / Childhood

10. Did you breastfeed your child? If yes, how long?

11. Did he/she have any digestion problems during infancy?

12. During infancy, do you remember your baby ever having a favorite side to sleep on? Did you ever notice a flat spot on their head?
13. Did he/she begin crawling normally? What month did crawling begin?

14. Which month did he/she begin walking?

15. Approximately when:

-could your child jump on one foot?

-could they tie their own shoes?

-could they ride a bike?

-stayed dry both daytime and nighttime?

16. Has your child ever been diagnosed with developmental delays in the following areas:

__ movement/motor __speech/understanding __socially

If any, what was the diagnosis and by which doctor?

17. Is your child right handed or left handed?

18. Does he/she have trouble concentrating?

19. Would you describe him/her as hyperactive?

20. Is your child often nervous or anxious?

21. How many hours does he/she sleep at night? Do they sleep alone in bed? Do they have trouble falling asleep or staying asleep?
22. What are their hobbies? Do they play sports?

23. Do they or have they ever had: (circle)
Asthma Allergies Constant coughing/respiratory infection
Chronic sinus infection Neurodermitis Epilepsy
constant earaches/middle ear infections
Underweight/overweight or other:

24. Does your child take medications or natural supplements? If yes, what are the doses?

25. How regular are their bowel movements? Do you notice a problem, ie. diarrhea, constipation, pain upon bowel movements, unwilling to go to the toilet?

26. How often has your child taken antibiotics?

27. Do they have food allergies or other allergies?

28. Has your child had any surgeries? Broken any bones? Falls?
Please explain:

29. Have they ever had Xrays? If yes, when and which bones?

30. Does your child wear glasses? If yes, since when?

31. What is the overall health like for his/her parents and siblings?

32. What are your expectations of this clinic?

33. How did you hear about us?

Acknowledgement and Consent of a minor:

_____

Parent's signature of child (patient) Date