LIFEForce Chiropractic

Patient questionnaire for children ages 6 - 14 years old

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 Email address

1. What brings you and your child to us?
Prevention or Symptoms? What are their symptoms?

Please go to the next page and show us (by marking) the area of pain or concern.

Dr. Gray's notes:

2. What exactly are your child's complaints and how long have they been complaining of it?

3. Are their symptoms constant or off and on?

4. What makes their symptoms worse?

5. Has your child gotten treatments for their complaints elsewhere? If yes, please tell us where, when and what for.

6. Who is their Pediatrician?

Pregnancy and Birth

7. Is this child your first birth? If not, how many siblings are there and what are their ages?

8. At your child's birth, did you need any medical intervention?

9. Was your child born on the 40th week of pregnancy? If not the 40th week, which week were they born?

10. Did you have a vaginal birth or C-section?

11. What was your child's health status after their birth?

12. How old were you when your child was born?

Infancy through Toddlerhood

13. Has your child had digestive problems during infancy?

14. Did your child go through the crawling stage? What month did they begin to crawl?

15. What month did they begin to walk?

16. Does your child have, or have they ever had, developmental delays in the following areas:

crawling/walking speech/understanding socializing

If yes to any above, please give more detail below and any diagnoses:

17. In school, does your child have problems in certain subjects and/or with certain tasks?

18. Do you notice any reading or writing challenges?

19. Is your child right or left handed?

20. Does your child have trouble concentrating? If yes, only at school or at home, too?

21. Would you describe your child as hyperactive?

22. Does your child easily get nervous or fearful?

23. How many hours does your child spend sleeping? Is that straight through sleep or waking up often?

24. What kind of hobbies does he/she like? Does he/she play sports? If so, how often and which ones?

25. Does your child have or have they ever had: (circle all that apply)

Allergies Asthma Chronic Sinus infections Skin problems Headaches Dizziness Heart problems Epilepsy Under/over weight
Other:

26. Does your child take medicines or natural supplements? If yes, name them and please include the doses.

27. How regular are your child's bowel movements? Daily? For instance, do they have: Diarrhea Constipation Tummy aches…. or they just don't want to go to the toilet.

28. In the past, how often has your child taken rounds of antibiotics?

29. Does your child have any food allergies?

30. Has he/she ever had an Xray? If so, when and which bone?

31. Has your child ever had surgery?

32. Were there ever any major accidents your child was involved in?

33. Does your child wear teeth braces? If yes, since when and why?

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

35. What is the general health status of his/her parents and grandparents?

36. Does he/she have a cell phone?

37. How much time does he/she spend on the cell phone/tablet/TV/computer?

38. When is bedtime?

39. What are your expectations of us helping you and your child?

40. How did you hear about us?

Acknowledgement and Consent of a minor:

_____

Parent's signature of child (patient) Date