



Lakes Chiropractic

Health Begins Here

Child & Adolescent Health Questionnaire

Your Name: _____ Birth Date: _____
Address _____ City _____ State _____ Zip _____
Telephone Number _____
Social Security number _____
Email Address _____
Mothers Name: _____ Fathers Name: _____
Siblings names and ages _____

How did you hear about our office? _____

Main Health Concern? (Main Complaint)

Any other Complaints/Other Health Challenges?

Which of the problems you checked off is/was the worst? _____

Is this problem: ___ constant ___ intermittent ___ occasional ___ cyclic

How long has it persisted? _____

When it is at its worst, how does it make your child feel? _____

What have you done about it that has not worked? _____

What makes it worse? _____

What makes it better? _____

Other Professionals seen for Main Health Concern: _____

Treatment and Results: _____

Does it interfere with the child's sleep? ___ eating? ___ daily routine? ___

Is the problem worse during a certain time of the day? ___N___Y

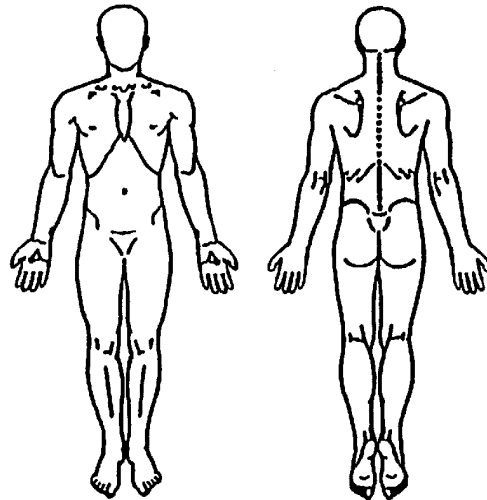
If so, what time of day? _____

If the problem worse or better since it first started? _____

What effect does this problem have on your child's body functions? _____

On his/her participation in daily activities? _____

Show area(s) of pain or unusual feeling.
Mark the areas on this body where your child feels the pain/dysfunction.
Mark areas of radiation. Include all affected areas.



Has your child/adolescent experienced any of the following?

- | | | |
|---------------------|----------------------------|---------------------------|
| ___ Headaches | ___ Numbness in arms/hands | ___ Foot/ankle/knee pains |
| ___ Dizziness | ___ Arm/wrist pains | ___ Tingling in arms/legs |
| ___ Ringing in ears | ___ Sleeping problems | ___ Neck/back pains |
| ___ Asthma | ___ Allergies | ___ Shoulder pains |
| ___ Hyperactivity | ___ Stomach problems | ___ "Growing Pains" |
| ___ Fatigue | ___ Weight gain/loss | ___ Other _____ |

Please explain the above: _____

Tell us about child's mothers pregnancy:

Did mom carry full term? _____

Any traumas to the mother during pregnancy? (i.e. falls, accidents, etc.) ___N___Y

If yes, please explain: _____

Describe any complications and when they occurred: _____

Tell us about delivery and birth of this child: _____

Baby born via C-Section? _____
Were forceps used? _____
Vacuum extraction? _____
Were you induced? _____
Pain medication? _____
Epidural used? _____
Was it a difficult birth? _____
What was the baby's APGAR Score at birth? _____ at 5 minutes? _____
Any evidence of trauma to the infant (please check all that apply)
____bruising _____stuck in birth canal
____fast or excessively long birth _____trouble breathing
____cord around neck _____odd shaped head
other: _____

Was child breastfeed? _____ How long? _____
Any difficulties with lactation? ___N___Y
Was child formula feed? _____ How long? _____ Which brand? _____
Introduced to solids at: _____ months, Cow's milk at _____ months
Food/Juice allergies? ___N___Y List: _____
Did mom consume alcohol during your pregnancy? _____ How much? _____
Did mom smoke during pregnancy? _____ How much? _____ How long? _____
Did mom take any medication during your pregnancy? _____
Please list which one(s) & the reason taken: _____

Any exposures to ultrasound? _____ How many? _____

Developmental History

During the following times your child's spine is most vulnerable to stress and should routinely be checked by a doctor of chiropractic for prevention and early detection of vertebral subluxation (spinal nerve interference). At what age was your child able to?

_____ Respond to Sound	_____ Cross Crawl
_____ Respond to Visual Stimuli	_____ Stand Alone
_____ Hold Head Up	_____ Walk Alone
_____ Sit Up	

According to the National Safety Council, approximately 50% of children fall headfirst from a high place during their first year of life (i.e., a bed, changing table, down stairs, etc.). Was this the case with your child? ___N___Y

Is/has your child been involved in any high impact or contact type sports (i.e., Soccer, Football, Gymnastics, Baseball, Cheerleading, Martial Arts, etc.)? ___N___Y

List: _____

Has Your Child Ever been involved in a Car Accident? ___N___Y

List: _____

Has Your Child been seen on an Emergency Basis? ___N___Y

List: _____

Other Traumas Not Described Above? ___N___Y, List: _____

Prior Surgery: ___N___Y, List: _____

Have they had Their First Menstrual Cycle? ___N___Y, Age: _____

As a baby/toddler, (birth to 4 years), did any of the following occur?

- | | |
|--|---|
| <input type="checkbox"/> Fall from a changing table | <input type="checkbox"/> Frequent crying spells |
| <input type="checkbox"/> Tumble down stairs | <input type="checkbox"/> Frequent bouts of diarrhea |
| <input type="checkbox"/> Fall out of crib | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Involved in a car accident | <input type="checkbox"/> Sleeping problems |
| <input type="checkbox"/> Fall off playground equipment | <input type="checkbox"/> Frequent colds |
| <input type="checkbox"/> Play in "Jolly Jumper" | <input type="checkbox"/> Frequent fevers |
| <input type="checkbox"/> Frequent ear infections | <input type="checkbox"/> Colic |
| <input type="checkbox"/> Tonsillitis | <input type="checkbox"/> Did not gain weight |
| <input type="checkbox"/> Reaction to vaccination | <input type="checkbox"/> Other _____ |

Please explain the above: _____

As a young child, (5-12 years), did any of the following occur?

- | | |
|--|--|
| <input type="checkbox"/> Fall from a tree | <input type="checkbox"/> Bed wetting |
| <input type="checkbox"/> Fall off a bicycle | <input type="checkbox"/> Hyperactivity/Autism |
| <input type="checkbox"/> Fall off playground equipment | <input type="checkbox"/> Learning difficulties |
| <input type="checkbox"/> Sports accident | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Car accident | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Stomach pains | <input type="checkbox"/> Leg/knee pains |
| <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Other _____ |

Please explain the above: _____

Any behavioral problems? ___N___Y Explain: _____

Any night terrors, sleep walking, sleep difficulties? ___N___Y Explain: _____

Age of child when began daycare? _____

Average number of hours of television per week? _____ Computer? _____

Playstation/Gameboy etc.? _____

Tell us about any vaccinations your child has had. _____

Any reaction to any of these? _____

Do you believe your child has to be "fully vaccinated" to attend
daycare/school? ___yes___ ___no___

Describe any hospital stays: _____

Approximately how many times have antibiotics

In the last six months _____ Total during his/her lifetime _____

What conditions did your child take antibiotics for?

List any medications your child is currently taking on attached page

Is there anything else you feel we should know? _____

**WE ARE HERE TO SERVE YOU, AND ENCOURAGED YOU TO
ASK QUESTIONS. YOUR PARTICIPATION IS VITAL AND WILL
HELP DETERMINE YOUR RESULTS.**

AUTHORIZATION FOR CARE OF MINOR

I hereby authorize this office and its Doctors to administer care to my Son/Daughter, as they deem necessary. I authorize the Doctors to take x-rays, perform an exam and render and necessary treatment. I clearly understand and agree that I am personally responsible for payment of all fees charged by this office.

Signed: _____ Date: ____/____/____

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic care has only one goal. It is important that each patient understand the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correcting of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by other. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxation.

I, _____ have read and fully understand the above statements
(print name)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

(signature)

(date)

Please list dates and body locations of any prior surgeries: _____

Prescription Medication Name	Taken for what condition/symptom	How long taken?
1.		
2.		
3.		
4.		
5.		
6.		

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Over the counter medication name	Taken for what condition/symptom	How long taken?
1.		
2.		
3.		
4.		
5.		
6.		

Vitamins/Minerals/Health Supplements	Taken for what condition/symptom	How long taken?
1.		
2.		
3.		
4.		
5.		
6.		