HEALTH QUESTIONNAIRE

Name: _____ DOB: _____ Parents Name: _____

Address: _____

Parent Email Address: _____

Parent Phone Number: _____

How did you discover our services: _____

About your child's health:

Please mark **YES or NO** where applicable and **Explain** where necessary:

Has your child had their spine looked at before? ◯ Yes / ◯ No

If yes, for what condition? _____

Were X-Rays Taken? ◯ Yes / ◯ No

Has your child ever suffered any injury or serious illness? ◯ Yes / ◯ No

If yes, please specify _____

_____

Please write in your own words your child's main complaint.

_____

_____

At the Child's Birth:

Was it chemically induced? ◯ Yes / ◯ No
Was a C-Section performed? ◯ Yes / ◯ No
Were forceps used? ◯ Yes / ◯ No

The child's symptoms in the past 6 months: (please tick)

Neck Pain	☐	Lower Back Pain	☐	Digestive Troubles	☐
Asthma	☐	Allergies	☐	Headaches	☐
Loss of Hearing	☐	Cold/Flu	☐	Sleeping Disorders	☐
Ear/Throat Infections	☐	Breathing Problems	☐	Fatigue	☐
Irritability	☐	Hyperactivity	☐	Bloody Noses	☐
Meningitis	☐	Diarrhea	☐	Constipation	☐
Bed Wetting	☐	Rashes	☐	Colic/Reflux	☐
Lactose Intolerance	☐	Sinus Problems	☐		

Was/Is your child breast fed or formula fed? If formula, what brand?

_____

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The child's current condition:

Is your child accident prone?	◯ Yes / ◯ No
Has the child had any falls down steps?	◯ Yes / ◯ No
Has your child ever fallen from heights over 2 feet?	◯ Yes / ◯ No
Has your child ever been involved in a motor vehicle accident?	◯ Yes / ◯ No
Has your child ever been hospitalized or had surgery?	◯ Yes / ◯ No
Has your child ever had any broken bones or sprain injuries?	◯ Yes / ◯ No
Is your child on medication?	◯ Yes / ◯ No
Has your child had a spinal curvature (scoliosis) examination?	◯ Yes / ◯ No
Does your child have a learning disorder?	◯ Yes / ◯ No
Does your child have poor posture?	◯ Yes / ◯ No
Is your child nervous, or has anyone suggested this?	◯ Yes / ◯ No
Does your child show signs of twitching or excessive talking?	◯ Yes / ◯ No

If you could improve one aspect of your child's health or behaviors, what would it be?

_____

_____

_____

_____

By signing this form, I agree and consent to the healing work on my child.

I understand this care is designed to assist the body with healing by helping to remove stressors from the body. I understand that healing takes time and there is no quick immediate fix to my problem, and health is a process.

Signature of Guardian/Parent: _____