

Nob Hill Family Chiropractic

1848 Nob Hill Road, Plantation, FL 33322

Ph: 954-476-8884 Fx: 954-476-2671

Child Health Questionnaire

Name: _____

Home Phone: _____

Address: _____

Email Address: _____

City, State, Zip _____

Birth Date: _____

Age: _____

Grade _____

1. Most patients are referred to our office by a caring family member or friend. What made you decide to visit our office? Friend/ Family Member Name: _____

Telephone Call Yellow Pages Sign Website Presentation Email

2. Research shows that spinal problems often begin at birth. How old was your child when they received their first chiropractic checkup? _____ Never

3. Difficult, long and/or doctor-assisted births can cause spinal misalignments. Was your child born by C-section, forceps, suction cup or other device? (Please circle) Yes No

4. How long was the actual labor and delivery time? _____

5. Have you ever been told that your child has a spinal curvature, spinal arthritis, or inherited spinal problem? Yes No

6. Poor posture leads to poor health and often indicates a spinal problem. How would you rate your child's posture? Poor- 1 2 3 4 5 6 7 8 9 10 - Excellent

7. Did your child have early health challenges such as colic or frequent ear infections?

Yes No

8. Does your child suffer from any of the following: (Please circle)

Allergies, Sinus problems, Bed-wetting, Difficulty concentrating, Attention deficit disorder

9. Does your child have other health problems that concern you?

- Please turn over -

10. Do you miss work or sleep often due to your child's illnesses? Yes No

11. Do you worry often about your child's health? Yes No

12. Do you have any health problems that affect your family? Please list _____

13. Prescription medications may cause various side effects hide the severity of health problems and hinder the body's ability to heal. What medications is your child currently taking?

14. Falls, sports impacts, and auto accidents can cause serious spinal problems. Is this visit related to an auto accident or injury? Yes No Date of Incident _____

15. If the doctor feels that your child will benefit from chiropractic care are you willing to follow his recommendations? Yes No

The above information is true and accurate to the best of my knowledge.

Parent/Guardian Signature _____ Date _____