Renovation Chiropractic 3035 Watson Blvd Warner Robins, GA 31093 Date: _______________

Child Chiropractic Health Questionnaire

Please complete this detailed history form and return it to the receptionist. Should you require any assistance, please let us know. We will be happy to assist.

Information

Child's Name: _____________________________ Parent(s) Name: _________________________

Home Phone: _____________________________ Parent's Cell Phone(s):_____________________

E-mail Address____

Home Address:
____

City: ____________________________State: ________________ Zip code: ___________________

Child's Birth Date (DOB) _____________ 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________________________
2. Research shows that spinal issues often begin at birth. How old was your child when they received their first chiropractic checkup?______________ Never_____
3. Difficult, long and/or extensive 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. Falls, sports impacts and auto accidents can cause serious health problems. Is this visit related to an auto accident or injury? Yes No Date of incident________________

8. 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?
   ____

The following information is very important because many of the problems that chiropractors work with are caused by stressors

A. History of Birth

Hospital/Birthing Center: □ Home □ Medical □ Midwife
Duration of Gestation: __________wks
Was the birth assisted? □ Yes □No If Yes, how? □Induction □Forceps □Vacuum □C-section
Were medications given to the mother during labor? □Yes □No
If Yes, what? __________________________________

B. Growth and Development

Was child alert and responsive within 12 hours of delivery? □Yes □No
If no, why? ______________________________
At what age did the child: Respond to sound? _______ Follow an object? ________
Hold up head? ________ Vocalize? ________
Sit up alone? _______ Teethe? _______ Crawl? ________ Walk? ________
Do their sleep patterns seem normal? _____________

C. Chemical Stressors

At any time during the pregnancy did the mother □ Smoke □ Drink
□Take prescription medication □Have chemical exposure
Was your child breastfed? □Yes □No If yes, then for how long? ______ Weeks □Months □Years
If no, then at what age was formula introduced? ________ Brand? _________________________
□Milk-based or □Soy-based?
Did your child receive vaccinations? □Yes □No If so which ones?
____
_ Did your child react to any vaccines? _________________.
Has your child had any rounds of antibiotics? ______________________

D. Psychological Stressors

Any difficulties with lactation? □Yes □No Any problems with bonding? □Yes □No
Does your child have any behavior problems? □Yes □No
Describe:
____
Does your child have difficulties sleeping (e.g. night terrors, sleepwalking, etc.) □Yes □No
Describe: ______________________
Did your child go to daycare? □Yes □No From what age? _____
Average number of hours of TV/Computer a week _____

 Date: _______________

E. Traumatic Stressors

Any evidence of trauma during birth? □Bruises □Odd shaped head □Stuck in the birth canal □Cord around neck □Excessively fast or short birth □Respiratory Depression
Other: ____

Any falls/accidents during pregnancy? □Yes □No
Has the child had any major falls, fractures or stitches? _________________
Any hospitalizations? □Yes □No
If yes, please explain: ____

Does your child play sports? □Yes □No
What sport(s): ______________________________ Beginning Age: _________________

PLEASE CIRCLE ALL CURRENT PROBLEMS YOUR CHILD MAY HAVE:

AUTISM	**CHRONIC SINUS**	**NIGHT TERRORS**
ADD/ADHD	**DIGESTIVE ISSUES**	**PLAGIOCEPHALY**
ALLERGIES	**DIFFICULTY CONCENTRATING**	**SPORTS INJURIES**
ASTHMA	**IRRTIBLE BOWEL SYNDROME**	**SCOLIOSIS**
BEDWETTING	**LOW IMMUNE SYSTEM**	**LATCHING PROBLEMS**
COLIC		**CONSTANT FEVERS**
EAR INFECTIONS		**OTHER** __________________

Any Other Health Concerns: List according to severity	Rate of Severity 1 = mild 10 = unbearable	When did this episode start?	If you had the condition before, when?	Did the problem begin with an injury?
1. ________________	____________	____________	____________	____________
2. ________________	____________	____________	____________	____________
3. ________________	____________	____________	____________	____________

Renovation Chiropractic 3035 Watson Blvd Warner Robins, GA 31093 Date: ______________

WRITTEN CONSENT FOR A CHILD

NAME OF PRACTICE MEMBER WHO IS A MINOR/CHILD

____

I AUTHORIZE DR. JOHN PETTYGROVE AND ANY AND ALL RENOVATION CHIROPRACTIC STAFF TO PERFORM DIAGNOSTIC PROCEDURES, RADIOGRAPHIC EVALUATIONS, RENDER CHIROPRACTIC CARE AND PERFORM CHIROPRACTIC ADJUSTMENTS TO MY MINOR/CHILD.
AS OF THIS DATE, I HAVE THE LEGAL RIGHT TO SELECT AND AUTHORIZE HEALTH CARE SERVICES FOR MY MINOR/CHILD. IF MY AUTHORITY TO SELECT AND AUTHORIZE CARE IS REVOKED OR ALTERED, I WILL IMMEDIATELY NOTIFY RENOVATION CHIROPRACTIC.

____ __________________

Parent / Guardian Signature Date

____

Guardian’s relationship to minor/child

____ __________________

Witness Signature Date