North Sea Chiropractic

Confidential Patient History

School-age child (6+ years)

Please complete this questionnaire and bring it to your first appointment.

Surname: _____ First name: _____
Address: _____
Post code: _____ City: _____
Telephone (home): _____ Date of Birth: _____
Name of Physician: _____
Address and telephone of Physician: _____
May we inform your physician over the course of your treatment? Yes / No BSN# (required): _____
Health Insurance: _____ Insurance Number: _____
How did you hear about North Sea Chiropractic: physician specialist advertisement
other, please list: _____
Contact Person (in case of emergency) and telephone: _____

HEALTH HISTORY

Reason for today's visit: _____

Does your child complain of pain or discomfort. If yes, when did this problem occur? _____
Was onset: □ sudden □ gradual Is problem: □ constant □ intermittent

Has your child ever had this problem before? □ Yes □ No _____

Has your child previously been treated for this problem? By whom? _____

Has your child previously had chiropractic care? □ Yes □ No _____

Does your child ever complain of back or neck pain? □ Yes □ No _____

Does your child ever complain of pains in the legs or arms? □ Yes □ No _____

Does your child ever complain of headaches? □ Yes □ No _____

Does your child have asthma? □ Yes □ No _____

Does your child ever had a problem with bedwetting? □ Yes □ No _____

Is your child allergic to anything? □ Yes □ No _____

Has your child had any earaches? □ Yes □ No At what age did the child's first earache occur? _____
How frequently does your child have earaches? _____
In which ear do your child's earaches usually occur? □ Right □ Left □ Both

Is your child presently taking any prescribed medication? □ Yes □ No _____

Please list any other illnesses that has been a concern for your child: _____

TRAUMA

Has your child had any recent falls or injuries? □ Yes □ No
Describe the trauma and the date it occurred: _____

Has your child ever fallen from a bicycle, skateboard, scooter, rollerblades, or similar? □ Yes □ No _____

Has your child ever fallen down stairs or fallen from a significant height? □ Yes □ No _____

Has your child ever been in a motor vehicle accident/collision or near-miss? □ Yes □ No _____

Has your child ever had a bone fracture or joint dislocation? □ Yes □ No _____

Does your child ever bang his/her head repeatedly against a wall, bed or other object? □ Yes □ No _____

Please list any surgeries your child has had: _____

NUTRITION

Do you have any concerns about your child's diet? □ Yes □ No _____

Does your child have any food allergies? □ Yes □ No _____

Does your child have any persistent or intermittently occurring skin rashes? □ Yes □ No _____

Does your child take vitamin supplements? □ Yes □ No _____

Does your child eliminate stools each day? □ Yes □ No _____

For how many months was your child breast-fed? _____

What does your child usually eat for breakfast? _____

What does your child usually eat for lunch? _____

What does your child usually eat for dinner? _____

What does your child usually eat for snacks? _____

How much cow's milk does your child drink each day? _____

How much water does your child drink each day? _____

How many sodas or colas does your child drink each day? _____

What is your child's favorite food? _____

How often and what type of fast foods does your child like to eat? _____

LIFESTYLE

How heavy is your child's school book bag? _____

What sports does your child play? _____

What hobbies does your child have? _____

How many hours each day does your child watch TV? _____

How many hours each day does your child spend using a computer? _____

How often does your child play video games? _____

On average, how many hours does your child sleep each night? _____

Are there any smokers in the child's home? □ Yes □ No _____

Does your child ever have blurred vision? □ Yes □ No _____

Does your child have trouble reading the board in class? □ Yes □ No Does your child wear □ glasses □ contact lenses

Does your child sometimes get headaches when he/she reads? □ Yes □ No _____

Patient Signature: _____ Date: _____