

Back In Action Chiropractic

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<http://www.back-n-action.com/>

Child Health Intake Questionnaire

Please complete this intake questionnaire. Your answers will help us to determine if we can help your child. If we do not sincerely believe your child's condition will respond satisfactorily, we will not accept your case. Thank you.

About The Child

Name _____

Date of Birth _____

Age _____

Height _____

Weight _____

Home Phone _____

Cell Phone _____

Work Phone _____

Home Address _____

Payment Method (Circle One)

Cash Check Credit Card

About the Parent

Name _____

Credit Card # _____

Employer _____

Expiration _____

Mother's Pregnancy and Labor

During pregnancy, did the mother:

1. Take any medications?.....Yes No
Explain _____
2. Smoke or consume alcohol?.....Yes No
3. Experience any illnesses?.....Yes No
Explain _____
4. Approximately how long did labor last?..... _____ hours
5. Was labor chemically induced?.....Yes No
6. Was labor doctor assisted?.....Yes No
7. Was a C-Section performed?.....Yes No
8. Were forceps or vacuum extraction used?.....Yes No
9. Did the delivery doctor pull or twist the baby during delivery?...Yes No
10. Was the delivery premature?.....Yes No
If "Yes", birth was at _____ months and weight was _____
11. Did the child experienced any of the following immediately after birth:
 1. Jaundice.....Yes No
 2. Respiratory problems.....Yes No
 3. Feeding problems.....Yes No
 4. Displaced or broken joints.....Yes No
 5. Other conditions.....Yes NoExplain _____
12. What was the APGAR score immediately after delivery?..... _____
13. What was the APGAR score 5 minutes after delivery?..... _____

Child's Health History

Please circle each of the conditions or diseases that applies to your child now or in the past. While they may seem unrelated to the purpose of the appointment, they can affect the overall diagnosis.

- | | | | |
|--------------------|--------------------|--------------------|--------------------|
| Vision problems | Allergies | Bed wetting | Frequent colds |
| Headaches | Breathing problems | Pink eye | Colic |
| Sleeping disorders | Asthma | Ear problems | Digestive problems |
| Irritability | Hyperactivity | Tubes in ears | Other problems |
| Skin problems | Constipation | Attention problems | |

If "Other problems", please explain: _____

Reason For This Visit

In general, what is your reason for seeking treatment? _____

Have you seen another healthcare practitioner for this condition?.....Yes No
If so, what were your results? _____

Has your child previously visited a chiropractor?.....Yes No
If so, when was your child's last adjustment? _____

What were the general results of that treatment? _____

Please list all minor and major surgeries (with dates if possible).

Nutritional

Please list all medications (including over-the-counter) your child is currently taking.

Please list all supplements (homeopathic, herbal, vitamins) your child is currently taking.

(Infants/toddlers only) Is your child currently breastfeeding?.....Yes No
If no, what formula(s) are you using? _____

Mother's dietary intake (To be completed by physician)

Child's Sleep Patterns

Hours of sleep per night: _____
Length of naps: _____
Naps per day _____

Child's Feeding Patterns (Infants/toddlers only)

Feedings per day: _____
Length of feedings: _____
Naps per day _____

Vaccines

Please list which vaccines you child has received and if there were any reactions, such as fever or cold.

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for their payment. I also understand that if I suspend or terminate my care and treatment, any professional fees rendered to me will be immediately due and payable.

Parent/Guardian's signature: _____

Date: _____

Doctor's signature: _____

Date: _____