Care Chiropractic Health & Rehab

PRE-TEEN PORTRAIT

6-12 YEARS

Patient's Name: ________________________________ AHC #: ____________________________ Date: _________________

Address: ____________________________________ Home Phone #: _____________________________ Sex: ☐ M ☐ F

Mother's Name: ________________________________Work Phone # : __________________Cell #:__________________

Father's Name: ________________________________Work Phone # : __________________Cell #:__________________

Birth Date: D/ __ M/ __ Y/ __ Age: ___ Weight: ___ Height: ___Reason for Child's visit:_____________________

LIFESTYLE QUESTIONS

1. Child spends most of the day with (please circle):

   Mother / Father / Grandparents / Public School / Home School / Private School

2. What is your child's hand dominance: ☐ Left ☐ Right
3. Did you child have prior health problems that they have outgrown/corrected? ☐ Yes ☐ No

   If yes, please explain ____

4. What is the child's bedtime? _____________________________ Number of hours of sleep/night:_________________
5. What is the child's quality of sleep (please circle): Good / Fair / Poor / Restless
6. Has your family experienced strong emotional distress such as (please circle):

   None of the following / Separation / Divorce / Loss of Parent / Loss of a sibling

   Recent death of someone close / Near Fatal Disease / Strong emotional upset / Other: ______________

7. Does your child awaken frequently with a regular complaint? ☐ Yes ☐ No
8. Recently has your child awakened complaining of pain? ☐ Yes ☐ No
9. Would you describe your child's health as: Very Robust / Very Good / Average / Poor / Sickly
10. How is your child's schooling progressing (please circle): No Concerns / Poorly / Average / Doing Well
11. Has there been a recent change in the child's energy level? ☐ Yes ☐ No
12. Does your child seem to be developing as you would expect regarding size, strength and co-ordination? ☐ Yes ☐ No
13. Are there any concerns with the child's diet? ☐ Yes ☐ No If yes, please explain ______________________________
14. Are you concerned with any of the following regarding bowel and bladder function?

    ☐ Regularity ☐ Stool Consistency ☐ Pain with Bowel Movements ☐ Bedwetting

HEALTH HISTORY

1. Please mark any of the following if they are a concern to you:

   ☐ Mouth breathing ☐ Snoring ☐ Tonsilitis ☐ Recurrent ear infection ☐Tubes in ears
   ☐ Hoarseness ☐ Recurrent throat infections ☐Difficulty breathing ☐Watery/Swollen Eyes
   ☐ Sinus infection ☐ Adenoids ☐ Recurrent Eye Infection

2. Please check any occurrence of Childhood diseases or conditions:

   ☐ Mumps ☐Measles ☐Chicken pox ☐ German measles
   ☐ Baby measles ☐ Anaemia ☐ Thrush ☐ Hernia
   ☐ Undescended testicles ☐ Appendix ☐ Other __________________

3. Does your child have or complain of frequent HEADACHES? ☐ Yes ☐ No

4. Does your child complain of pain or soreness in the legs, knees, ankles, or feet? ☐ Yes ☐ No

5. Does your child complain of pain or soreness in the arms, elbows, wrists, or hands? ❑ Yes ❑ No

6. Is your child currently (or recently) taking any of the following medications? ❑ Yes ❑ No

❑ Antibiotics, for what: __________________________ ❑ Tylenol ❑ Aspirin ❑ Other medications: ________________

7. Is your child following an immunization program? ❑ Yes ❑ No

8. Has your child had any reaction to the immunization program? ❑ Yes ❑ No

9. Has your child had any allergic reactions to any medications? ❑ Yes ❑ No

10. Does your child have any problems with dry scaly skin or persistent rashes? ❑ Yes ❑ No

11. Is your child showing any signs of having Asthma or Bronchitis? ❑ Yes ❑ No

12. Has your child been examined by an allergist? ❑ Yes ❑ No

13. Is your child having allergy shots? ❑ Yes ❑ No

14. Has your child ever been hospitalized? ❑ Yes ❑ No If yes, why? __________________________________

15. Has the child had any broken bones: ❑ Yes ❑ No If yes, explain __________________________

16. Has your child ever experienced a dislocation? ❑ Yes ❑ No

17. Has your child ever been involved in a motor vehicle accident? ❑ Yes ❑ No

18. Have you child ever received any major trauma? ❑ Yes ❑ No

19. Has your child ever had any trauma to the spine? ❑ Yes ❑ No

20. Has there ever been a problem in the child's walking? ❑ Yes ❑ No

21. Do you have any concern regarding your child's walking pattern? ❑ Yes ❑ No

❑ Limp ❑ Toe Walking ❑ Scoliosis ❑ Pain

❑ Foot Positioning ❑ Unusual Wear on Shoes ❑Other

22. Date of last visit to GP: _______________ Name: ____________________ Purpose: ____________________________

23. Date of last visit to Pediatrician: _____________ Name: _____________________Purpose: ______________________

24. Has your child had any reason to see a Dentist? ❑ Yes ❑ No If yes,

Date of Dentist Appointment:__________ Name:____________________ Purpose: ______________________________

25. Does your child frequently have a low grade fever? ❑ Yes ❑ No

26. Is there a history of high recurrent fevers? ❑ Yes ❑ No

27. Does the child presently have a fever ❑ Yes ❑ No

28. Have you noted a history of frequent, recurrent swollen lymph nodes? ❑ Yes ❑ No

29. Does your child have a bloated or distended abdomen? ❑ Yes ❑ No

30. Have you noted any changes or difficulty with speech? ❑ Yes ❑ No

31. Are there any hereditary health problems? ❑ Yes ❑ No

32. Is your child involved in a physical education program? ❑ Yes ❑ No

33. Is your child having any visual problems? ❑ Yes ❑ No

34. Have your child's eyes been checked by an optometrist or an ophthalmologist? ❑ Yes ❑ No

35. Do you have any concerns regarding your child's health this questionnaire has failed to address ❑ Yes ❑ No

If yes, please state:____

_____________________________ _________________________________ _________________

Parent's Printed Name **Parent's Signature** **Date**