Jackson Family Chiropractic
Child Chiropractic Health Questionnaire

Name _____ Phone Number to Best Reach Child or Parent_____

Address _____ City/State/Zip _____

Birthdate _____ Age_____ Height _____Weight_____

Email Address _____ Grade in School _____ Referred by _____

Please answer the following questions:

* **What is your complaint (the biggest health concern)?** _____ When did it begin? _____

****One complaint per section, please!**

How did this problem begin? _____

Have you had this condition in the past? YES NO Is your condition: BETTER WORSE NOT CHANGING

Which side is your complaint on? LEFT RIGHT BILATERAL CENTRAL

Please rate your pain on a scale of 1 to 10 (0=no pain and 10= excruciating pain): **1 2 3 4 5 6 7 8 9 10**

How intense is your complaint? NO EFFECT MINIMUM MILD MODERATE SEVERE UNBEARABLE

Describe the nature of your symptoms: BURNING DULLACHE NUMB SHARP SHOOTING TIGHTNESS
TINGLING THROBBING RADIATES TO: _____

How often do you experience your symptoms? CONSTANTLY (76-100% of the day) FREQUENTLY (51-75% of the day)
OCCASSIONALLY (26-50% of the day) INTERMITTENTLY (0-25% of the day)

What makes your symptom better? ACUPUNCTURE CHIROPRACTIC HEAT ICE MASSAGE THERAPY
NOTHING WORKS PAIN MEDS PHYSICAL THERAPY REST STRETCHING

What activities aggravate your condition? _____

*** What is your second biggest health concern?** _____ When did it begin? _____

How did this problem begin? _____

Have you had this condition in the past? YES NO Is your condition: BETTER WORSE NOT CHANGING

Which side is your complaint on? LEFT RIGHT BILATERAL CENTRAL

Please rate your pain on a scale of 1 to 10 (0=no pain and 10= excruciating pain): **1 2 3 4 5 6 7 8 9 10**

How intense is your complaint? NO EFFECT MINIMUM MILD MODERATE SEVERE UNBEARABLE

Describe the nature of your symptoms: BURNING DULLACHE NUMB SHARP SHOOTING TIGHTNESS
TINGLING THROBBING RADIATES TO: _____

How often do you experience your symptoms? CONSTANTLY (76-100% of the day) FREQUENTLY (51-75% of the day)
OCCASSIONALLY (26-50% of the day) INTERMITTENTLY (0-25% of the day)

What makes your symptom better? ACUPUNCTURE CHIROPRACTIC HEAT ICE MASSAGE THERAPY
NOTHING WORKS PAIN MEDS PHYSICAL THERAPY REST STRETCHING

What activities aggravate your condition? _____

Turn Page Over To Finish Application

*** What is your third biggest health concern?** _____ When did it begin? _____

How did this problem begin? _____

Have you had this condition in the past? YES NO Is your condition: BETTER WORSE NOT CHANGING

Which side is your complaint on? LEFT RIGHT BILATERAL CENTRAL

Please rate your pain on a scale of 1 to 10 (0=no pain and 10= excruciating pain): **1 2 3 4 5 6 7 8 9 10**

How intense is your complaint? NO EFFECT MINIMUM MILD MODERATE SEVERE UNBEARABLE

Describe the nature of your symptoms: BURNING DULLACHE NUMB SHARP SHOOTING TIGHTNESS
TINGLING THROBBING RADIATES TO: _____

How often do you experience your symptoms? CONSTANTLY (76-100% of the day) FREQUENTLY (51-75% of the day)
OCCASSIONALLY (26-50% of the day) INTERMITTENTLY (0-25% of the day)

What makes your symptom better? ACUPUNCTURE CHIROPRACTIC HEAT ICE MASSAGE THERAPY
NOTHING WORKS PAIN MEDS PHYSICAL THERAPY REST STRETCHING

What activities aggravate your condition? _____

**Do you have more complaints? YES NO. Please describe: _____

_____

Falls, sports impacts and auto accidents can cause serious spinal problems. Is this visit related to a (please circle one)
FALL SPORTS IMPACT AUTO-ACCIDENT OTHER

Please describe incident _____ Date of Incident_____

Research shows that spinal problems often begin at birth. How old was your child when they received their first chiropractic checkup (circle one) ?
NEVER 0-2 YEARS 2-5 YEARS 5-12 YEARS

Difficult, long and/or doctor assisted births can cause spinal misalignments. Was your child born by (circle one)
VAGINALLY C-SECTION FORCEPS SUCTION CUP OTHER_____?

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

Did your child have early health challenges such as colic, irritability or frequent ear infections? Yes No

Does your child have other health problems that concern you? _____

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

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

Is your child currently taking prescription medication? Yes No If so, how many? _____

Is your child fully vaccinated? Yes No If not, reason? _____

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

How will you be paying for today's visit? Credit/Debit Card Cash Check Other_____

The above information is true and accurate to the best of my knowledge. Copies of any x-rays and reports will be released upon written request, however original x-rays remain the property of the clinic.

Parent/Guardian Signature _____ Date _____