Child's Chiropractic Health Questionnaire

Date: _____ Email: _____ Receive E-letter? ☐ Yes ☐ No

Child's Name _____ Home Phone _____
Address _____ City, State, Zip _____
Birth date _____ Age _____ Student? _____ Grade _____

Parent/Guardian's Name _____Relationship to Child _____
Address _____ Work Phone _____
City, State, Zip _____Cell Phone _____
Birth date _____ Age _____ SS# _____
Occupation _____Employer_____
Emergency Contact/Phone _____/_____
Marital Status: (circle one)____ S M D W ____ No. of Children _____
Spouse Name/Occupation _____/_____

Some patients are referred to our office by a caring family member or friend. What made you decide to visit our office? Friend or Family Member Name _____ or
□ Sign □ Website □ Presentation □ TV □ Newspaper □ Facebook

If Dr. King feels that care will help you, are you willing to follow his recommendations? □ Yes □ No

Please list all your reasons for visiting our office:

1._____2._____3._____

Insurance, Acknowledgements, Permission and Signature

Insurance Carrier _____ID_____
(We will copy your Driver's License and Insurance Card on your 1st appointment.)
I authorize release of any information necessary to process my insurance claims and assign and request payment directly to my physician.

Payment: I assume full responsibility for payment of services rendered by Dr. Channing King D.C. I understand that I am responsible for all attorney fees or collection fees related to the collection of my account. I agree to pay interest at the rate of 1.5% per month (18% per annual) on any unpaid balance.

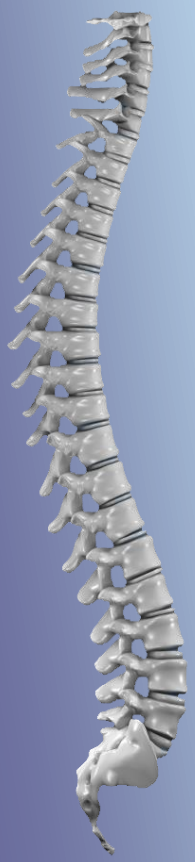
Privacy Policies: In addition, I consent to the use and disclosure of protected health information by Dr. Channing J. King, D.C, his staff and business associates for treatment, payment, health care operations and additional uses listed within. I have reviewed, acknowledged, and understand the content of the *Notice of Privacy Practices.* (Copy available at front desk)

I give King Family Chiropractic permission to perform a complete chiropractic consultation, examination and any diagnostic x-rays on _____.

Parent/Guardian's Signature if a minor

_____

Welcome to our office! It is well known that people who maintain strong and healthy neurological, structural and metabolic systems have much improved health. People whose systems are not kept in proper health are much more likely to have or to develop some type of chronic disorder.



402 Main Street
Trussville, AL 35173
Phone: 205-655-0010
KingFamilyChiropractic.com

Complaints - Please list any health symptoms or health complaints you are experiencing.

Complaint 1 _____

When did this first begin? _____Have you ever experienced this before? _____
What makes it worse? _____What makes it better? _____
Describe the type of pain you experience. _____
Does the problem travel into any other area of your body? ____ If so, where? _____
Have you lost control of any body parts? (arms, legs, bladder, bowel, etc.)? _____
Rate the severity of your problem on a scale of 1-10, 1 being least severe and 10 being bedridden. _____

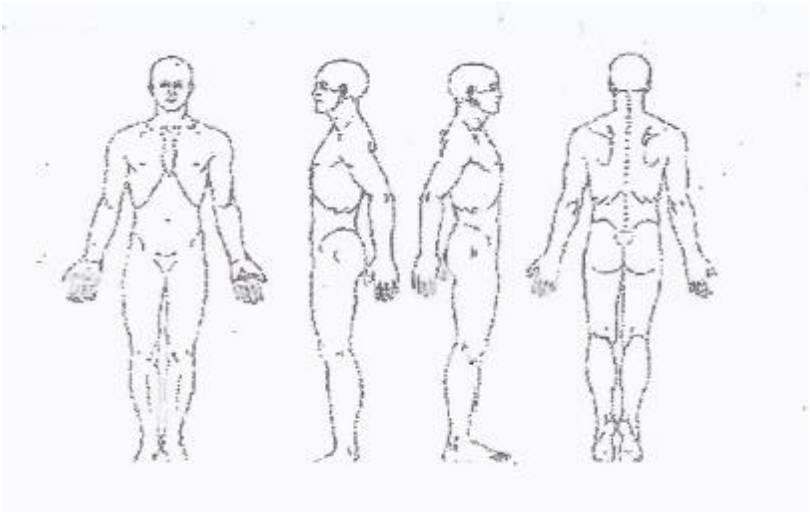
Complaint 2 _____

When did this first begin? _____Have you ever experienced this before? _____
What makes it worse? _____What makes it better? _____
Describe the type of pain you experience. _____
Does the problem travel into any other area of your body? ____ If so, where? _____
Have you lost control of any body parts? (arms, legs, bladder, bowel, etc.)? _____
Rate the severity of your problem on a scale of 1-10, 1 being least severe and 10 being bedridden. _____

Complaint 3 _____

When did this first begin? _____Have you ever experienced this before? _____
What makes it worse? _____What makes it better? _____
Describe the type of pain you experience. _____
Does the problem travel into any other area of your body? ____ If so, where? _____
Have you lost control of any body parts? (arms, legs, bladder, bowel, etc.)? _____
Rate the severity of your problem on a scale of 1-10, 1 being least severe and 10 being bedridden. _____

Please mark off the areas of your complaint on the diagram below. Use the following symbols:
P = pain, N = numbness, T = tingling, B = burning, C = Cramping



Please list any surgeries, accidents, fractures and illnesses you have experienced.

_____
_____
_____
_____

List any medical doctors you have consulted in the past year.

Name: _____Reason _____
Name: _____Reason _____
Name: _____Reason _____

List all **medications** you take. (RX and OTC) Use the back of this sheet if needed.

Drug Name	Dosage	For what condition	How long have you taken?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

List all **supplements** you take. Use the back of this sheet if needed.

Drug Name	Dosage	For what condition	How long have you taken?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Check ALL 'body signals (symptoms/pain) you may have had or do have now.

___ADD/ADHD	___Depression	___Hepatitis	___ Miscarriage
___Alcoholism	___Diabetes	___High Blood Pressure	___ Multiple Sclerosis
___Allergy	___Diarrhea	___High Cholesterol	___Neck Pain
___Alzheimer's	___Eczema	___High Blood Sugar	___ Parkinson's disease
___Anemia	___Emphysema	___HIV/AIDS	___Pneumonia
___Appendicitis	___Epilepsy/seizures	___Irregular Periods/Cramps	___Raynaud's
___Asthma	___Fibromyalgia	___Irritable Bowel	___Rheumatoid Arthritis
___Arthritis	___Gall Bladder	___Kidney infections/stones	___Ringing in Ears
___Back pain	___Goiter	___Low Blood Pressure	___Sinus infections
___Cancer	___Gout	___Low Blood Sugar	___Stroke
___Celiac/Gluten Dis?	___Headaches	___Lyme Disease	___Thyroid Problems
___Chronic Fatigue	___Heart Attack	___Lupus	___Ulcers
___Constipation	___Heart Disease	___Migraine	___Vertigo/dizziness

Spinal health is especially important during pregnancy. Is there any chance that you are pregnant? □ YES □ NO

Please check all of the following conditions your family has experienced.

Mother	__Alzheimer's __Cancer __Diabetes __Heart Disease __Parkinson's __MS __Stroke
Father	__Alzheimer's __Cancer __Diabetes __Heart Disease __Parkinson's __MS __Stroke
Grandmother (M)	__Alzheimer's __Cancer __Diabetes __Heart Disease __Parkinson's __MS __Stroke
Grandfather (M)	__Alzheimer's __Cancer __Diabetes __Heart Disease __Parkinson's __MS __Stroke
Grandmother (P)	__Alzheimer's __Cancer __Diabetes __Heart Disease __Parkinson's __MS __Stroke
Grandfather (P)	__Alzheimer's __Cancer __Diabetes __Heart Disease __Parkinson's __MS __Stroke
Sister(s)	__Alzheimer's __Cancer __Diabetes __Heart Disease __Parkinson's __MS __Stroke
Brother(s)	__Alzheimer's __Cancer __Diabetes __Heart Disease __Parkinson's __MS __Stroke

List any other health conditions that you or your family have had that are not listed:

_____

Do you consume any of the following? (Leave blank what does not apply)

Tobacco products: Packs a day? ___ How many years? ___ Alcohol: ___ Drinks a day? ___How many years? ___

Coffee/Tea: Cups a day? ___ Regular or decaf? ___ Soft Drinks: Drinks a day? ___ Regular or diet? ___

Do you use artificial sweeteners? ○Yes ○No If yes, please list _____

Level of exercise: ___ none ___Moderate (days per week) ___Strenuous (days per week)

Have you experienced any <u>unexplained or rapid</u> weight changes in the last six months? ○Yes (___ lbs. loss/gained) ○ No

Research shows that your spine should be checked regularly.

How many times have you visited a chiropractor in your lifetime? _____

Name: _____Reason _____

Name: _____Reason _____