

Parent/Child Health Questionnaire

Please complete for children age 10 and younger

Name of Parent _____	Name of Child _____
Home phone # _____	Date of Birth _____ Sex M F
Work phone # _____	Email _____
Address _____	Address (if different from parent) _____
City _____ State _____ Zip _____	City _____ State _____ Zip _____
Who is responsible for your child's bill? <input type="checkbox"/> You <input type="checkbox"/> Spouse <input type="checkbox"/> Auto Insurance <input type="checkbox"/> Health Insurance _____	

During Pregnancy, were you on medication? _____

Did you smoke or consume any alcoholic beverages? _____

Was there back pain? _____

Approximately how long was labor? _____

Were you physically ill? (colds, flu, allergies, etc.) _____

Regarding Labor:

- | | Yes | No | |
|-------------------------------------|--------------------------|--------------------------|--------------------|
| ▶ Was it chemically induced? | <input type="checkbox"/> | <input type="checkbox"/> | |
| ▶ Doctor assisted? | <input type="checkbox"/> | <input type="checkbox"/> | |
| ▶ Was C-Section performed? | <input type="checkbox"/> | <input type="checkbox"/> | |
| ▶ Were forceps used? | <input type="checkbox"/> | <input type="checkbox"/> | |
| ▶ Did Dr. have hands on the infant? | <input type="checkbox"/> | <input type="checkbox"/> | |
| ▶ Were you lying down? | <input type="checkbox"/> | <input type="checkbox"/> | |
| ▶ Was a family member present? | <input type="checkbox"/> | <input type="checkbox"/> | If yes, who? _____ |
| ▶ Was the baby premature? | <input type="checkbox"/> | <input type="checkbox"/> | |

If so, what was his/her age and weight? _____

(95% of all infants were born with hands on or forceps)

Did your child suffer any health problems, such as:

	Yes	No		Yes	No
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Meningitis	<input type="checkbox"/>	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
Ear Problems	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>
Sleeping Disorders	<input type="checkbox"/>	<input type="checkbox"/>	Colic	<input type="checkbox"/>	<input type="checkbox"/>
Breathing Problems	<input type="checkbox"/>	<input type="checkbox"/>	Rashes	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Bed Wetting	<input type="checkbox"/>	<input type="checkbox"/>
Irritability	<input type="checkbox"/>	<input type="checkbox"/>	Digestive Problems	<input type="checkbox"/>	<input type="checkbox"/>
Hyperactivity	<input type="checkbox"/>	<input type="checkbox"/>	Milk or Lactose Intolerance	<input type="checkbox"/>	<input type="checkbox"/>
Frequent Colds	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____		
Flu	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Bloody Noses	<input type="checkbox"/>	<input type="checkbox"/>	_____		

Regarding you child today:

	Yes	No
Is your child accident prone:	<input type="checkbox"/>	<input type="checkbox"/>
Has the child had any falls down steps?	<input type="checkbox"/>	<input type="checkbox"/>
Has your child ever fallen from heights over 2 feet?	<input type="checkbox"/>	<input type="checkbox"/>
Has your child ever been involved in a motor vehicle accident?	<input type="checkbox"/>	<input type="checkbox"/>
Has your child ever been hospitalized or had surgery?	<input type="checkbox"/>	<input type="checkbox"/>
Does your child suffer from:	Yes	No
Allergies	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Has your child ever had any broken bones or sprain injuries?	<input type="checkbox"/>	<input type="checkbox"/>
Is your child on any medication?	<input type="checkbox"/>	<input type="checkbox"/>
Has your child had a scoliosis examination by an approved scoliosis determination procedures clinic?	<input type="checkbox"/>	<input type="checkbox"/>
Is your child hyperactive?	<input type="checkbox"/>	<input type="checkbox"/>
Does your child have learning disorders?	<input type="checkbox"/>	<input type="checkbox"/>
Sleeping difficulty?	<input type="checkbox"/>	<input type="checkbox"/>
Poor posture?	<input type="checkbox"/>	<input type="checkbox"/>
Does your child have any problem associating with friends?	<input type="checkbox"/>	<input type="checkbox"/>
Is your child nervous, or has anyone suggested that your child was nervous?	<input type="checkbox"/>	<input type="checkbox"/>
If you could improve one aspect of your child's health or behavior, what would it be?		