# CHIROPRACTIE RUGKLINIEK HEERLEN

**CONFIDENTIAL QUESTIONNAIRE FOR CHILDREN (up to 12 years)**

**Please fill in with red**

Surname: ……..……
Initials: ……..……M/V
First name:……
Date of birth:……..…..
Address:……..……
Zip:……..……
City:……..……
Referred by: …….

E-mail address:……..
Home phone:……..……..……...
Work parents phone……..……..……...
Mobile phone:……..……..……
BSN no:…….....
Health insurance + no.:……
M.D.:……..……
M.D. address:…….....……..
Hobbies/Sports: ……..…..……

**What is the major complaint?**
……..……
……..……
……..……
……
……

**How long has your child have this . condition?**……
……..

**What is the cause of this complaint?**
……
……
……

**How did the complaint begin?**
☐ Gradually
☐ Suddenly

**Is the complaint:**
☐ Intermittently present
☐ Constantly present

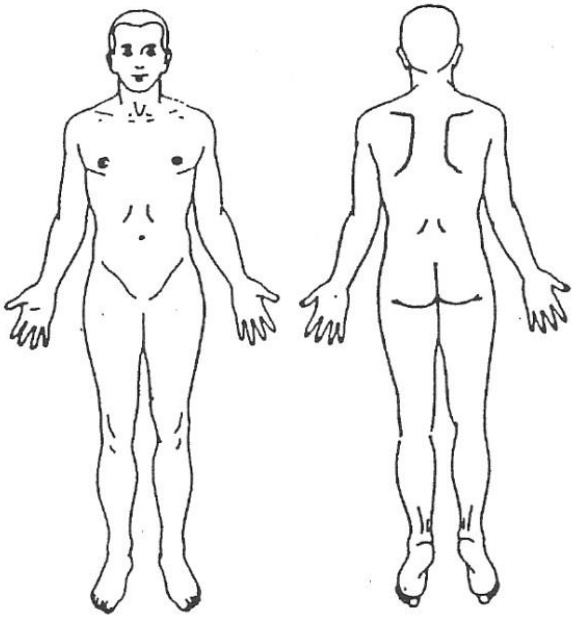
**Delivery:**
☐ Forceps
☐ Vacuum
☐ Caesarean
☐ Breach delivery
☐ Complications:……..
Born after ….. weeks of pregnancy
as …… child in your family
Breast fed Yes/No up to …… months

**Does your child display:**
☐ Hyperactivity
☐ Concentration problems
☐ Abnormal behavior:…….
……

**Abnormalities:**
☐ Hereditary:……..
☐ Chromosomal:……..
☐ Retardation in:……
☐ Other:……..

**Medical professionals:**
*Did your child see one of these professionals for his/her complaints:*
☐ Chiropractor
☐ Family doctor
☐ Physiotherapist
☐ Manual therapist
☐ Podotherapist
☐ Neurologist
☐ Rehabilitation doctor
☐ Osteopath
☐ Acupuncturist
☐ Surgeon
☐ Pediatrician
☐ Homeopathic doctor
☐ Orthopedist
☐ Psychologist
☐ Alternative doctor
☐ Other professionals:
……

**Please specify where the complaint is:**



**Muscle and joint problems**
**Past/Present**
☐ ☐ Neck
☐ ☐ Between the shoulders
☐ ☐ Lower back
☐ ☐ Tailbone
☐ ☐ Groin L/R
☐ ☐ Hip L/R
☐ ☐ Leg L/R
☐ ☐ Knee L/R
☐ ☐ Foot or heel L/R
☐ ☐ Jaw
☐ ☐ Shoulder L/R
☐ ☐ Arm L/R
☐ ☐ Elbow L/R
☐ ☐ Hand L/R
☐ ☐ Wrist L/R
☐ ☐ Finger L/R
☐ ☐ Ribs L/R
☐ ☐ Bursitis
☐ ☐ Swollen joints

**General:**
**Past/Present**
☐ ☐ Headache
☐ ☐ Migraine
☐ ☐ Dizziness
☐ ☐ Fainting
☐ ☐ Difficulty sleeping
☐ ☐ Nervousness
☐ ☐ Allergies
☐ ☐ Depression
☐ ☐ Loss of appetite
☐ ☐ Ear, nose, throat, eye complaints
☐ ☐ Sinusitis
☐ ☐ Ear infections L/R
☐ ☐ Loss of hearing L/R

**Cardio-vascular**
**Past/Present**
☐ ☐ Heart disease
☐ ☐ Anemia
☐ ☐ Poor circulation

**Dental:**
☐ ☐ Grinding/clenching
☐ ☐ Popping noise

**Respiratory**
**Past/Present**
□ □ Difficulty breathing
□ □ Asthma
□ □ Bronchitis
□ □ Pneumonia
□ □ Emphysema
□ □ Hay fever
□ □ Chest pain
□ □ Coughing up slime:
□ □ Chronic cough

**Sleeping position:**
□ Back
□ Side
□ Stomach
□ Variable
**How old is your child's mattress?**……..

**Gastro-intestinal**
**Past/Present**
□ □ Stomach pain
□ □ Hiatus hernia
□ □ Gall bladder problems
□ □ Liver problems
□ □ Vomiting/Nausea
□ □ Flatulence
□ □ Bladder/urinary problems
□ □ Nephritis
□ □ Inability to control bladder
□ □ Diarrhea
□ □ Abdominal pain
□ □ Constipation

**Does your child use:**
**Past/Present**
□ □ Arch support or thotics
□ □ Heel lifts/bars L/R
□ □ Other: ……

**Illnesses**
**Past/Present**
□ □ Epilepsy
□ □ Cancer
□ □ Multiple sclerosis
□ □ Polio
□ □ Meningitis
□ □ Tuberculosis
□ □ Diabetes
□ □ Thyroid disease
□ □ Mononucleosis

**Skin**
**Past/Present**
□ □ Dry skin
□ □ Itching
□ □ Eczema
□ □ Bruise easily
□ □ Other: …….

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**Please fill out as completely as possible even if it seems not relatated to your child's complaint(s).**

□ Accidents: ……..……
……
□ Bone fractures:……
……
□ Surgical operations: ……..……
……
□ Hospitalizations: ……..……..……..
……
□ Medications and for what: ……
……
□ Nutrient vitamins and minerals? □ Ja □ Nee
Which? : ..…….

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| **Date of last tests:** | **Less than 6 months.** | **Between 6-18 months.** | **More than 18 months.** | **Never** |
|---|---|---|---|---|
| Urine test: | □ | □ | □ | □ |
| X-rays | □ | □ | □ | □ |
| MRI /CT | □ | □ | □ | □ |
| Blood test: | □ | □ | □ | □ |
| Chiropractic examination: | □ | □ | □ | □ |
| Medical examination: | □ | □ | □ | □ |

| **Habits:** | **Above normal** | **Normal** | **Less than normal** | **Geen** |
|---|---|---|---|---|
| Appetite: | □ | □ | □ | □ |
| Sport or exercise: | □ | □ | □ | □ |
| Sleep: | □ | □ | □ | □ |

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**Remarks?**.....
.....
.....

**May we contact or inform your M.D.?** Yes / No * * Circle as appropiate.
If nothing is circled, we reserve the right to inform your doctor..

**Signature:** .....
**Date:** ……