

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:.....
 Home phone:.....
 Work parents phone.....
 Mobile phone:.....

E-mail address:.....
 Hobbies/Sports:
 Referred by:
 M.D.:.....
 M.D. address:.....

May we contact or inform your M.D.? YES / NO
 (Circle as appropriate

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:

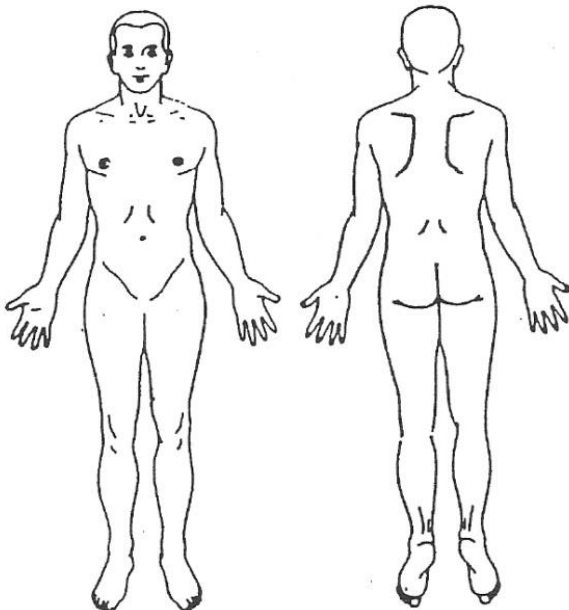
- Hereditary:.....
- Chromosomal:.....
- Retardation in:.....
- Other:.....

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:

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

- Accidents:
- Bone fractures:.....
- Surgical operations:
- Hospitalizations:
- Medications and for what:
- Nutrient vitamins and minerals? Yes No
Which? :
- Has your child been recently vaccinated? Yes No
Which? :

Date of last tests:	Less than 6 months.	Between 6-18 months.	More than 18 months.	Never
Urine test:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
X-rays	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
MRI /CT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood test:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chiropractic examination:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medical examination:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Habits:	Above normal	Normal	Less than normal	Geen
Appetite:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sport or exercise:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Remarks?.....
.....
.....

Signature:

Date: