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/are the complaint(s)?
…….……
……..……
…….……
…….
…….
How long has your child have this/these complaint(s)?……
……..
What is the cause of this/these complaint(s)?
…….
…….
…….

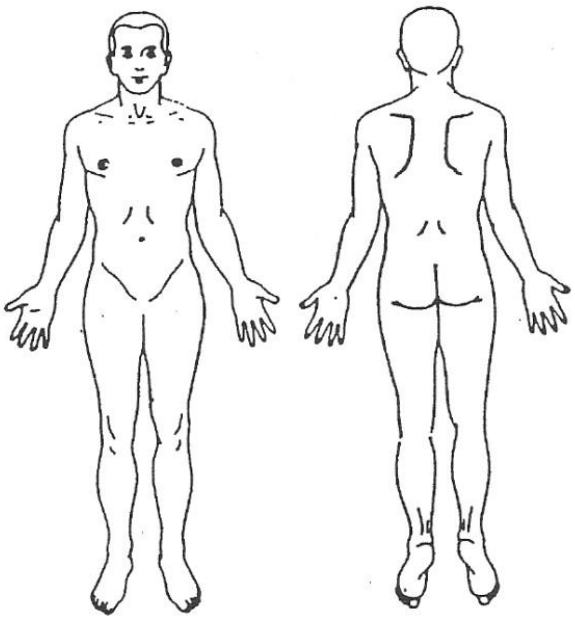
How did the complaint begin?
☐ Gradually
☐ Suddenly
Is the complaint:
☐ Intermittently present
☐ Constantly present

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 relatated 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:	□	□	□	□
X-rays	□	□	□	□
MRI /CT	□	□	□	□
Blood test:	□	□	□	□
Chiropractic examination:	□	□	□	□
Medical examination:	□	□	□	□

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

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

Signature: .....

Date: ……