



Consent for Chiropractic Treatment of a Minor Child

I hereby authorize Dr. Heath McKinley and whomever he may designate as his assistants to administer treatment as he so deems necessary to my child _____.

First name last name

I acknowledge that I am the parent or legal guardian and I am responsible for all reasonable charges in connection with care and treatment rendered during this period. I have read this form and certify that I understand its contents.

Name _____

Mother, Father or Legal Guardian -Print

Signature _____ Date: _____

Mother, Father or Legal Guardian -Signature



INITIAL CHILD & ADOLESCENT QUESTIONNAIRE

PERSONAL INFORMATION:

Child's Name: _____
 First Middle Last

Mom: _____ Dad: _____

Address: _____

Phone Number: _____

Birth Date: Month: _____ Day: _____ Year: _____

Present Physician: _____ City: _____

MAINLY FOR MOMS:

1. Describe your pregnancy in as much detail as possible.

Did you carry to full term? _____

Describe any complications and when they occurred:

2. Tell us about your delivery and birth of this child:

Did you use a midwife? _____ Hospital: _____ Obstetrician? _____

Did you have a C-Section: _____ Were forceps used? _____

Vacuum Extraction? _____ Was delivery induced? _____

Did you have an Epidural? _____ Was it a difficult birth? _____
What was the baby's APGAR Score? _____ at 5 minutes? _____

3. Tell us more:

Did you breastfeed? _____ How long? _____ What formula after? _____

Did you consume alcohol during your pregnancy? _____ How much? _____

Did you smoke? _____ How much? _____ How long? _____

Did you take any medication during your pregnancy? _____

For what? _____ What type? _____

Any exposure to ultrasound? _____ How many? _____

4. As a baby/toddler (birth to 4 years) did any of the following occur?

- | | | |
|---|--|--|
| <input type="checkbox"/> Fall from a change table | <input type="checkbox"/> Tumble down stairs | <input type="checkbox"/> Play in a Jolly Jumper |
| <input type="checkbox"/> Involved in car accident | <input type="checkbox"/> Fall off playground equipment | <input type="checkbox"/> Fall out of crib |
| <input type="checkbox"/> Frequent Ear Infections | <input type="checkbox"/> Tonsillitis | <input type="checkbox"/> Reaction to vaccination |
| <input type="checkbox"/> Frequent Crying Spells | <input type="checkbox"/> Frequent Fevers | <input type="checkbox"/> Frequent bouts of diarrhoea |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Colic | <input type="checkbox"/> Frequent colds/illness |
| <input type="checkbox"/> Trouble gaining weight | <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Other: _____ |

Please explain the above: _____

5. As a young child (5 - 12 years) did any of the following occur?

- | | | | |
|---|---|--|------------------------------------|
| <input type="checkbox"/> Fall from a tree | <input type="checkbox"/> Fall off a bicycle | <input type="checkbox"/> Fall off playground equipment | |
| <input type="checkbox"/> Sports accident/injury | <input type="checkbox"/> Car accident | <input type="checkbox"/> Stomach Pains | <input type="checkbox"/> Scoliosis |
| <input type="checkbox"/> Bed Wetting | <input type="checkbox"/> Hyperactivity/Autism | <input type="checkbox"/> Learning Difficulties | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Leg/Knee Pains | <input type="checkbox"/> Other _____ | |

Please explain the above: _____

6. Tell us about any vaccinations your child has had: _____

Any reaction to any of the above listed that you know of? _____

Were you told that you had a choice in vaccinating your child? Y N

Would you like information on the other side of this issue? Y N

Did you know your child DOES NOT need to be vaccinated to attend school? ___ Y ___ N

(*Please let us know if you would like a vaccination exemption form)

7. As a child or adolescent, has your child experienced any of the following:

- | | | |
|---|--|--|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Ringing in Ears |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Arm/Hand Numbness | <input type="checkbox"/> Arm/Wrist Pain | <input type="checkbox"/> Sleeping Problems |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Stomach Problems | <input type="checkbox"/> Weight Gain/Loss |
| <input type="checkbox"/> Foot/Ankle/Knee Pain | <input type="checkbox"/> Tingling in Arms/Legs | <input type="checkbox"/> Neck/Back Pains |
| <input type="checkbox"/> Shoulder Pain | <input type="checkbox"/> Growing Pains | <input type="checkbox"/> Other _____ |

Please explain the above:

8. Which of the problems that you have checked off is the worst/greatest concern?

Is this problem: Constant ___ Intermittent ___ Occasional ___ Cyclic ___

9. How long has it persisted?

10. When it is at its worst, how does it make your child feel? _____

11. What have you done about it that has NOT worked? _____

12. What makes it worse? _____

13. What effect does this problem have on your child's body functions? _____

On his/her participation in daily activities? _____

14. Describe any hospital stays? _____

15. Approximately how many times have antibiotics been prescribed and for what conditions?

16. List any medications your child is currently taking: _____

17. To summarize, what is your purpose/goal for this appointment? _____

18. Is there any other information you would like us to be aware of?

Parent/Guardian Signature: _____ **Date:** _____