mckinley family chiropractic
A WELLNESS CENTER

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

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INITIAL CHILD & ADOLESENT 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?

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

Please explain the above: _____

_____

_____

_____

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

☐ Fall from a tree	☐ Fall off a bicycle	☐ Fall off playground equipment	
☐ Sports accident/injury	☐ Car accident	☐ Stomach Pains	☐ Scoliosis
☐ Bed Wetting	☐ Hyperactivity/Autism	☐ Learning Difficulties	☐ Asthma
☐ Allergies	☐ Leg/Knee Pains	☐ 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:

☐ Headaches	☐ Dizziness	☐ Ringing in Ears
☐ Asthma	☐ Hyperactivity	☐ Fatigue
☐ Arm/Hand Numbness	☐ Arm/Wrist Pain	☐ Sleeping Problems
☐ Allergies	☐ Stomach Problems	☐ Weight Gain/Loss
☐ Foot/Ankle/Knee Pain	☐ Tingling in Arms/Legs	☐ Neck/Back Pains
☐ Shoulder Pain	☐ Growing Pains	☐ 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:** _____