BRITTON Chiropractic & Rehab Clinic

Early Childhood History Questionnaire

Date:_____ **Pt. File #:**_____
Doctor:_____

Name:_____ Social Security #:_____

Age:_____ Birth Date:_____ Race:_____ # of Siblings:_____

Parent's Names:_____

Address:_____ City:_____ State:___ Zip:_____

Home Phone:_____ Cell Phone:_____

Work Phone:_____

1. How were you referred to our office? _____
2. Family Medical Doctor:_____
3. What is the contact information for your MD?_____
4. Purpose of this appointment? _____
5. Date of onset of any conditions?_____
6. Has a physician treated you for any health condition in the last year?π Yesπ No
7. If yes, describe:_____

   _____
8. What medications or drugs is the child taking and what are they for?_____

   _____
9. What supplements or herbs is the child taking and why?_____

   _____
10. Has the child had any vaccinations?_____ Which vaccinations?_____
11. What things were noticed after the vaccinations?_____

    _____
12. Please list any other major OR minor health concerns you have about your child:

    _____
13. Did the mother have any illnesses during pregnancy?_____ If yes, explain:_____

    _____
14. Was the child carried to term?_____
15. Where was your baby born?_____
16. What was the weight of the child at birth?_____
17. Did the child have problems with breathing when born?_____
18. Did your baby have any trouble in first week of life?_____

19. Any problems with the labor or delivery?_____
20. What techniques were used during delivery?_____
21. Is/ how long the child nursed?_____
22. What is the child's appetite like?_____
23. Do any foods bother the child?_____
24. Does the child have diarrhea or constipation?_____
25. Did your child sit alone before 7 months of age?_____
26. Did your child walk alone before 15 months?_____
27. Did your child say any words by 1.5 years of age?_____
28. Is the child as quick in learning as your other children?_____
29. How many hours per day of TV does your child watch?_____
30. Does/did your child have/had:
    a. Eczema or hives:_____
    b. Wheezing or asthma:_____
    c. Allergies or reactions to meds or injections?_____
    d. Constant cold, hay fever, or sinus trouble?_____
31. Are both parents in good health?_____
32. How many people live in your home?_____
33. Does anyone who lives with, or takes care of, the child smoke?_____
34. Has the child:
    a. Had more than 6 colds or throat infections per year?_____
    b. Had more than 3 ear infections?_____
    c. Had any trouble seeing?_____
    d. Had any trouble with teeth?_____
    e. Had any trouble passing urine?_____
    f. Had any trouble passing fecal matter?_____
    g. EVER had a convulsion or fit or fainting spell?_____
    h. Had 3-day measles, 10-day measles, Chicken Pox, Mumps, Whooping cough, or Pneumonia? Please list:_____
    i. Had any serious accidents: Burns, Poisoning, Falls, Cuts?_____
35. Has the child been treated with chiropractic care?_____
36. Has the child been treated with acupuncture?_____
37. Any questions or concerns that you need answered?

_____

_____

AUTHORIZATION AND RELEASE: I authorize payment of worker's compensation and personal injury insurance benefits directly to the chiropractor or chiropractic office. I understand and agree to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations and coordination of care. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

Patient's Signature_____ Date_____

Guardian's Signature Authorizing Care_____ Date_____

Doctor's Signature _____ Date _____

CONSENT TO TREATMENT OF MINOR CHILD

I hereby authorize **Dr. Britton** and whoever he may designate as his assistants to administer treatment as he so deems necessary to my _____,_____.

Dated at **Britton Chiropractic and Rehab Clinic** this _____day of _____, _____.

Signed:_____

Witnessed: _____