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Wellness Rhythms
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Personal Injury Questionnaire

Dear Patient, in our efforts to better serve you, please complete the following questionnaire and return it to the office. Thank you!

Name of Parent: _____ Name of Child: _____
Address: _____
City, State, & Zip: _____
Phone: (home) _____ (work)_____ (cell)_____
Parent Email Address: _____
Date of Birth: ____/____/____ Age: _____ Sex:
How did you hear about our office? _____
Has your child ever received spinal adjustments by a Chiropractor before?
If yes, when and by who? _____ How long did your child go? _____
Have you or your partner ever received chiropractic care?
What other natural forms of healthcare has your child received? _____
What do you hope for your child to gain from Chiropractic care in this office? _____
_____

Please answer the following questions about your child's health history:

Was there any physical illness prior to the pregnancy?
Was the pregnancy difficult?
During pregnancy, were there any falls, accidents or physical injuries?
Was labor chemically induced?
During labor was 'mom' (check one):

(☐) Conscious (☐) Subconscious (☐) Unconscious

Was the birth (check one):

(☐) Drug Induced (☐) Breech (☐) Cord around Neck
(☐) Forceps or Suction (☐) Natural
(☐) C- Section (☐) Prolonged

Was the birth (check one):

(☐) at Home (☐) at Hospital
(☐) at Birthing Center (☐) Other: _____

Was your child incubated or isolated?
Was your child (check all that apply):

(☐) Bottle Fed (☐) Breast Fed (☐) Other: _____

Has your child experienced any of the following?
If so, please check all that apply, and make additional comments as to when your child experienced those symptoms:

(☐) Headaches (☐) Breathing Problems (☐) Hyperactivity
(☐) Allergies (☐) Fatigue (☐) Frequent Colds
(☐) Ear Infections (☐) Irritability (☐) Flu

(☐) Bloody Noses
(☐) Meningitis
(☐) Diarrhea
(☐) Colic
(☐) Constipation
(☐) Rashes
(☐) Asthma
(☐) Lactose
(☐) Intolerance
(☐) Bed Wetting
(☐) Sleeping Disorders
(☐) Digestive Problems
(☐) Other: _____

Additional comments: _____
_____
_____

Regarding your child today:

Has your child ever been unconscious?
Is your child accident-prone?
Has your child had any falls down steps?
Has your child ever been involved in an auto accident?
Has your child ever been hospitalized or had surgery?
Has your child ever had any broken bones or sprain injuries?
Is your child on any medications?
If yes, which medications: _____
Has your child been vaccinated?
Is your child in any sports?
If yes, which sports? _____
Does your child have any learning disorders?
Does your child have poor posture?
Is your child nervous, or has anyone suggested that your child was nervous?
How would you rate your child's physical health? (check one):

(☐) Excellent
(☐) Good
(☐) Fair
(☐) Poor
(☐) Getting Better
(☐) Getting Worse

How would you rate your child's emotional/mental health? (check one):

(☐) Excellent
(☐) Good
(☐) Fair
(☐) Poor
(☐) Getting Better
(☐) Getting Worse

Is there anything else you may wish to share which may help us to better understand your child? _____
_____

I hereby authorize the doctor(s) at Wellness Rhythms to administer care as they deem necessary to my son/daughter.

Name: _____ Date: _____

Signed: _____ Witness: _____