FAMILY FIRST CHIROPRACTIC

6788 Thorold Stone Road
Niagara Falls, Ontario
L2J 1B4

Dr. Heather Robson-McInnis, D.C.

(ph) 905-358-8717
(fx) 905-358-7951

PARENT / CHILD UPDATE QUESTIONNAIRE

Note: Injury to the spine during the birth process, as well as the numerous falls and accidents during childhood, could be the unsuspected cause of many health problems in children.

Name of child: _____

Address: _____ City: _____

Postal Code: _____

Phone Number _____ Sex of the child: Male / Female

Date of Birth: _____ Age of the child: _____

Email: _____

Name of Parent: _____

Address (if different from child): _____

Does or did your child suffer any health problems such as:
(please circle all that apply)

Headaches	Irritability	Diarrhea
Allergies	Hyperactivity	Constipation
Ear problems	Frequent colds	Colic
Sleeping disorders	Flu	Rashes
Breathing problems	Digestive problems	Milk or lactose intolerance
Fatigue	Meningitis	Bed wetting

Other:_____

_____

_____

Has your child had any adverse reactions to any vaccinations? If so, please list what vaccination, the age of your child at the time and what reactions occurred.

_____

_____

_____

Please Turn Over

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PARENT / CHILD UPDATE QUESTIONNAIRE cont'd

Regarding your child today:
(please check those that apply)

Is your child accident prone? _____

Has the child had any falls down the steps? _____

Has your child ever fallen from heights over 2 feet? _____

Has your child ever been involved in a motor vehicle accident? _____

Has your child ever been hospitalized or had surgery?_____

Has your child had a scoliosis exam? _____

Is your child hyperactive? _____

Does your child have learning disorders?_____

Does your child have sleeping difficulties? _____ Poor posture? _____

Does your child have any problem associating with friends? _____

Is your child nervous, or has anyone suggest that your child was nervous? _____

Does your child show any signs of nervousness, twitching, or excessive talking to themselves? _____

If you could improve one aspect of your child's health or behaviour, what would it be?

_____

_____

Does your child suffer from: Allergies ____ Asthma ____ Headaches ____

Has your child every had any broken bones or sprain injuries? _____

Is your child on any medication? _____

Consent to treatment

I, the child's legal parent or guardian, hereby request and consent to the performance of chiropractic adjustments and procedures, including various modes of diagnostic testing, on my child by the doctor of chiropractic name below:

_____ _____
Print Child's Name Signature of Parent/Guardian

_____ _____
Witness Date

Please Turn Over