

Kliver Chiropractic & Wellness

PATIENT INTRODUCTION

Personal Information:

Your Name:

Your Address:

Telephone Number: _____
Home Business Cell

E-mail Address:

Birth Date: _____

Marital Status: _____

Occupation: _____

Employer: _____

Previous Chiropractor: _____ City:

Reason for leaving:

Present MD: _____ City:

Referred to our Center by:

Please understand that any fees incurred at Kluver Chiropractic that will not be paid by insurance/third party, will be the patient's personal responsibility.

I give my consent to have the doctor take any x-ray he/she deems appropriate to better understand my problem and monitor my progress.

SIGNATURE: _____ DATE:

(Signature of Parent/Guardian required if patient under age of 18)

THANK YOU!

Kliver Chiropractic & Wellness

Initial Child & Adolescent Questionnaire

Your

Name: _____

Your Mom: _____ Your

Dad: _____

Mainly for Moms:

1. Tell us about your pregnancy:

Did you carry full term? _____

Describe any complications and when they occurred: _____

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

Did your use a
midwife? _____
Hospital? _____

Obstetrician? _____

Did you have a C-Section?

Were forceps used?

Vacuum Extraction?

Were you induced?

Did you have an
epidural? _____

Was it a difficult
birth? _____

3. Tell us more:

Did your breastfeed? _____ If yes, how
long? _____

What formula did you use
after? _____

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

Did you smoke? _____ How
much? _____

Did you take any medication during your
pregnancy? _____

For what? _____ What
type? _____

Any exposures to ultrasound? _____ How
many? _____

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

- | | |
|-------------------------------------|----------------------------------|
| _____ Fall from a change table | _____ Frequent crying spells |
| _____ Tumble down stairs | _____ Frequent fevers |
| _____ Fall out of crib | _____ Frequent bouts of diarrhea |
| _____ Involved in car accident | _____ Constipation |
| _____ Fall off playground equipment | _____ Sleeping problems |

- Play in Jolly Jumper
- Frequent ear infections
- Tonsillitis
- Reaction to vaccination

- Frequent colds
- Colic
- Did not gain weight
- 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
- Car accident
- Stomach pains
- Scoliosis

- Bed wetting
- Hyperactivity/Autism
- Learning difficulties
- Asthma
- Allergies
- Leg/knee pains
- Other

Please explain the above: _____

Tell us about any vaccinations your child has had and any reaction they may have had: _____

Were you told you had a choice of vaccinating your child? ___Yes ___No

Would you like information on the other side of this issue? ___Yes ___No

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

- Headaches
- Dizziness
- Ringing in ears
- Asthma
- Sleeping problems

- Numbness in arms/hands
- Foot/ankle/knee pains
- Arm/wrist pains
- Tingling in arms/legs
- Neck/back pains

_____ Hyperactivity
_____ Shoulder pains
_____ Fatigue
_____ Weight gain/loss

_____ Allergies
_____ Stomach problems
_____ Growing pains
_____ Other

Please explain the above: _____

Which of the problems you have checked off is the worst? _____

Is this problem: Constant____, Intermittent____, Occasional____, Cyclic____

How long has it persisted? _____

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

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

What makes it worse? _____

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

On his/her daily activities? _____

7. Describe any hospital stays: _____

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

9. List any medications your child is currently taking? _____

10. To summarize, what is your purpose for this appointment? _____

11. Is there anything else you feel we should know? _____

**Signature of Parent/
Guardian:** _____

Date: _____

THANK YOU!