Child Chiropractic Health Questionnaire

Name ____ Home Phone ________________________________

Address ______________________________________

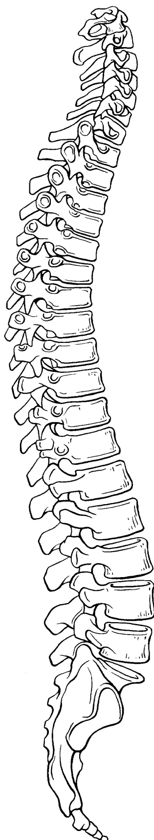
City, State, Zip ____

Birth date ______________________ Age __________ Grade ________Male_______Female _______

E-mail Address _________________________________ Social Security # ___________________________

Parent/Guardian ________________________________ Cell Phone___________________________________

Welcome to our office! It is well known that families who maintain strong healthy, well-aligned spines have much improved health. People whose spines are not kept in proper alignment are much more likely to develop health disorders later in life such as arthritis, illness, pain, heart attacks, strokes, even cancer.



1. Most patients are referred to our office by a caring family member or friend. What made you decide to visit our office? Friend/Family Member Name ______________________________________

☐ Telephone Call ☐ Yellow Pages ☐ Sign ☐ Website ☐ Presentation ☐ E-mail

2. Research shows that spinal problems often begin at birth. How old was your child when they received their first chiropractic checkup? _______ ☐ Never

3. Difficult, long and/or doctor-assisted births can cause spinal misalignments. Was your child born by C-section, forceps, suction cup or other device? (Please circle) ☐ YES ☐ NO

4. How long was the actual labor and delivery time? ____

5. Have you ever been told that your child has a spinal curvature, spinal arthritis, or inherited spinal problem? ☐ YES ☐ NO ____

6. Poor posture leads to poor health and often indicates a spinal problem. How would you rate your child's posture? Poor - 1 2 3 4 5 6 7 8 9 10 - Excellent

7. Did your child have early health challenges such as colic or ear infections? ☐YES ☐NO

8. Does your child suffer from any of the following: allergies, sinus problems, bed-wetting, difficulty concentrating, attention deficit disorder? (Please circle)

9. Does your child have other health problems that concern you? ___________________________

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10. Do you miss work or sleep due to your child's illnesses? ☐ YES ☐ NO

11. Do you worry often about your child's health? ☐ YES ☐ NO

12. Do you have any health problems that affect your family? Please list ______________________

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13. Prescription medications may cause various side effects, hide the severity of health problems and hinder the body's ability to heal. What medications is your child currently taking?

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14. Falls, sports impacts and auto accidents can cause serious spinal problems. Is this visit related to an auto accident or injury? ☐ YES ☐ NO Date of Incident ____________________

15. If the doctor feels that your child will benefit from chiropractic care are you willing to follow his/her recommendations? ☐ YES ☐ NO

The above information is true and accurate to the best of my knowledge.

*Parent/Guardian Signature*________________________________ *Date*____________________

Consent to Treatment of Minor Child

I hereby authorize McCormick Chiropractic of Pottstown, PA and whomever they may designate as assistants to administer chiropractic care as deemed necessary to my ________________________________(indicate relationship of child), ___________________________________(name of child).

Parent/Guardian Signature_______________________________ **Date**_______________________

Parent/Guardian Name:__________________________________ Phone: _______________ Cell:_______________

Name of Parent/Guardian ***responsible*** for Patient's Account: ____

Address (if different from address of patient): ____

Phone: ______________________ Cell:___________________

INSURANCE AUTHORIZATION:

Does patient have health insurance? ________________ Name of Company____

Subscriber's Name ______________________________ Date of Birth ____________________ SS# ________________________

Subscriber's Relationship to Patient:_____________________

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payers and to secure the payment of benefits. 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.

Subscriber Signature_______________________________ Date_______________________