Name:_____ Date:_____

CHILDREN'S HEALTH QUESTIONNAIRE

(12 Years Old and Younger)

Height: _____ Weight (lbs.): _____

Please check any of the following symptoms your child has had presently or in the past.

Present	More than a year ago		Present	More than a year ago	
_____	_____	Headache	_____	_____	Poor Circulation
_____	_____	Fainting or Dizziness	_____	_____	Difficulty with Urination
_____	_____	Convulsions	_____	_____	Kidney or Bowel trouble
_____	_____	Allergies	_____	_____	Difficult Digestion
_____	_____	Ringing or infection in the Ears	_____	_____	Nausea
_____	_____	Difficulty Breathing	_____	_____	Neck Pain
_____	_____	Swelling of the Ankles	_____	_____	Back Pain
_____	_____	Blurred Vision	_____	_____	Pain Radiating to Arms / Legs
_____	_____	Numbness or tingling in Arms or Legs			
_____	_____	Weakness of Hands or Arms			
_____	_____	Joint Pain at Shoulder, Elbow or Wrist			
_____	_____	Joint Pain of Ankle, Knee or Hip			

In case of Emergency : Name: _____ Phone # (_____) _____ - _____

Has your child ever been told they have any disease? (Syndrome) Ex: Diabetes, ADHD, Palsy etc.

_____

Have they had any form of Cancer?_____

Any Family History of Cancer?_____

Are they Physically Active? If yes, what Activities / Sports?

_____

Are there spinal or neurological troubles in your family?_____

List Any Medications they are taking presently, or have taken in the past 3 months:

_____

List all prior surgeries, if any:

_____

List all prior accidents, falls, or broken bones, if any: (Ex: Fall down stairs, highchair, out of crib etc.)

_____

Any problems with Pregnancy: ☐Yes ☐No; Delivery: ☐C-Section ☐Forceps ☐ Other: _____

Immunizations / Vaccinations: ☐Yes ☐No; Adverse Reactions: ☐Yes ☐No
Specify shots: _____When: _____

Does child have a good appetite: ☐Yes ☐No; Proper Food: ☐Yes ☐No