



Children's Questionnaire

Date: _____

Phone (Home) _____

Name: _____

Phone (Office) _____

Name of parent or legal guardian: _____

Address: _____

Age: _____ Date of birth: _____

Who referred you to this office? _____

Name of Chiropractor: _____

Name of family Doctor: _____

What is your chief concern about your child's health? _____

If your child has a chronic illness, how long has he or she had this condition?

Who diagnosed the illness? _____

When was this diagnosis made? _____

What specialists has your child seen? (Indicate the year of the consultation)



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How has this illness been treated until now?

How long has it been since your child has been totally well?

Could you list the major symptoms affecting your child?

1.

2.

3.

4.

5.

6.
