Dr. Joe Demyen
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Canton, GA 30115
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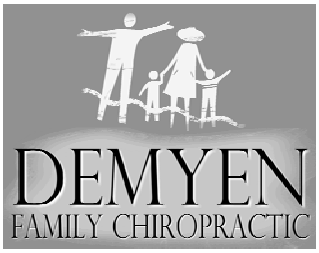


www.demyenchiro.com

Patient # _____

"A Revolutionary Approach to Healthcare!"

CHILD HEALTH HISTORY QUESTIONNAIRE

We are happy you have chosen to have your child's nervous system checked! Many types of stressors (physical, mental, and chemical) can interfere with your child's growing brain, spine and nervous system. Nervous system health is an exciting new concept for many people, so PLEASE ask questions.

Child's Name _____ Date of Birth _____ Age _____

Mother's Name _____ Father's Name _____

Reason for consulting our office _____

Previous Chiropractic Care? Y or N If Yes, with whom? _____

How long was care received? _____ Reason for stopping care? _____

CIRCLE APPROPRIATELY:

Birth Place: Home / Birth Center / Hospital **Type:** Vaginal / C-Section

Procedures: Forceps / Vacuum Extraction **Epidural?** Y or N **Pain Medication?** Y or N

Was Delivery Long? Y or N **Was Delivery Difficult?** Y or N **Labor Induced?** Y or N

Was Baby Breech/In-Utero Constraint? Y or N

Was Baby Breast Fed? Y or N **If Yes, Duration?** _____

CIRCLE APPROPRIATELY:

Which sports does/did your child participate in?

Soccer / Football / Gymnastics / Cheerleading / Karate / Basketball / Dance / Other _____

According to the National Safety Council, approximately 54% of infants fall head-first from a high place (bed, changing table, etc.) during their first year of life. **Has this happened to your child?** Y or N Comments _____

List any other falls or accidents _____

MEDICATIONS:

How many rounds of antibiotics has your child taken in the last 6 months? _____ Lifetime? _____

Present prescription drugs: _____

Past prescription drugs: _____

Over the counter drugs (Tylenol, cough syrup, laxatives, etc.): _____

OVER →

Patient # _____

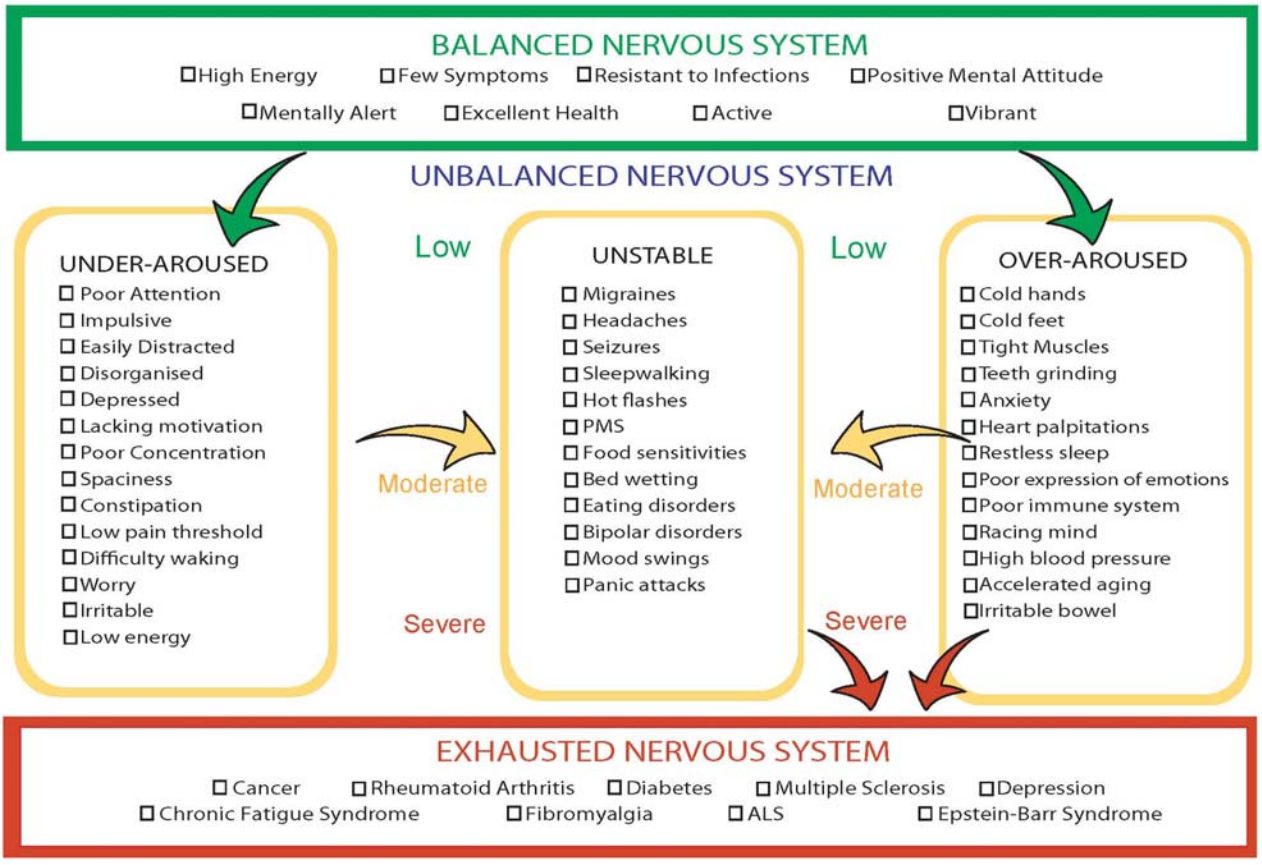
Check any of the following your child has suffered from:

___ Ear Infections
___ Asthma/Allergies
___ Digestive Problems
___ Chronic Colds
___ ADD/ADHD
___ Recurring Fevers
___ Growing/Back Pains
___ Colic
___ Other _____
___ Scoliosis
___ Head Banging

List date and year of any surgeries or hospitalizations _____

_____

Please check all symptoms your child has ever had, even if they do not seem related to their current problem and check the box where they fit on the chart. Your doctor will then be able to recommend what type of care they need to achieve balance . . .



Compiled from the work By Siegfried Othmer, Susan F. Othmer, and David A. Kaiser EEG Biofeedback: A Generalized Approach to Neuroregulation

FINANCIAL INFORMATION:

Person responsible for account: _____

Are you planning to use some type of insurance? Y or N

_____ _____

Parent/Guardian Signature *Date*