



# Levinson Family Chiropractic Health Questionnaire



**Child**  
-Please Print-

**Patient I.D. #:** \_\_\_\_\_

**Date:** \_\_\_\_\_

<b>Child's Name:</b> _____		<b>Home Phone:</b> _____	
<b>Address:</b> _____		<b>Date of Birth:</b> _____	<b>Sex:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female
		<b>Referred by:</b> _____	
<b>Responsible Party's Name:</b> _____	<b>Relationship:</b> _____	<b>Child's Social Security #:</b> _____	
<b>Address (if different than above):</b> _____		<b>Insured's Name:</b> <i>Age:</i> _____	
		<b>Insurance Co. Name:</b> _____	<b>Policy #:</b> <i>on file</i>

**What is your major complaint? Please describe:**

<b>What type of delivery:</b> <input type="checkbox"/> Vaginal <input type="checkbox"/> C-Section	<b>Child's weight at birth:</b> _____	<b>Any medication used during delivery?:</b> <input type="checkbox"/> Y <input type="checkbox"/> N <b>If yes, what was used?</b> _____	<b>Was child born more than 2 weeks early or late?:</b> <input type="checkbox"/> No <input type="checkbox"/> Yes: _____	<b>Was/is child breast-fed?:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
--	--	--	--	--

<b>Falls, Accidents, Injuries:</b>	<b>Month, Year:</b>	<b>Type of Accident:</b>	<b>Describe Injury:</b>

<b>Has child ever had surgery?</b>	<b>Month, Year:</b>	<b>Type of Surgery:</b>	<b>Complications/Other Comments:</b>

<b>Is child presently taking medications or vitamins?</b>	<b>Name of Drug:</b>	<b>Doses Per Day:</b>	<b>Length of Time Taking:</b>

<b>Has your child been to a Chiropractor before?</b> Yes <input type="checkbox"/> No <input type="checkbox"/>	<b>If yes, who?</b>	<b>Where?</b>	<b>When?</b>	<b>What were the results?</b>

Please check any of the following that have given your child difficulty or that your child has recently had:

- |   |   |   |   |
|---|---|---|---|
| <input type="checkbox"/> Headaches 784.0              | <input type="checkbox"/> Fainting 780.2                   | <input type="checkbox"/> Shortness of breath 786.09   | <input type="checkbox"/> Ulcers 534.9                   |
| <input type="checkbox"/> Shooting head pains 784.0    | <input type="checkbox"/> Loss of balance 781.2            | <input type="checkbox"/> Mid-back pain 724.1          | <input type="checkbox"/> Numbness-legs or feet 782.0    |
| <input type="checkbox"/> Sinus trouble 473.9          | <input type="checkbox"/> Ringing in ears 388.3            | <input type="checkbox"/> Heart attack 410.9           | <input type="checkbox"/> Constipation 564.0             |
| <input type="checkbox"/> Loss of smell 781.1          | <input type="checkbox"/> Blurred vision 368.0             | <input type="checkbox"/> High blood pressure 401.9    | <input type="checkbox"/> Kidney trouble 593.9           |
| <input type="checkbox"/> Allergies 995.3              | <input type="checkbox"/> Lights bother eyes 368.13        | <input type="checkbox"/> Low blood pressure 458.9     | <input type="checkbox"/> Menstrual cramps/pain 625.3    |
| <input type="checkbox"/> Hayfever 477.8               | <input type="checkbox"/> Neck pain 723.1                  | <input type="checkbox"/> Anemia 285.9                 | <input type="checkbox"/> Menstrual irregularity 626.4   |
| <input type="checkbox"/> Asthma 493.9                 | <input type="checkbox"/> Muscle spasms in neck 781.0      | <input type="checkbox"/> Stomach trouble 789.0        | <input type="checkbox"/> Diabetes 250.0                 |
| <input type="checkbox"/> Loss of taste 781.1          | <input type="checkbox"/> Grinding in neck 719.68          | <input type="checkbox"/> Nerves and nervousness 799.2 | <input type="checkbox"/> Sleeping problems 780.5        |
| <input type="checkbox"/> Inflammation of throat 462.0 | <input type="checkbox"/> Tightness of shoulder/arm 728.85 | <input type="checkbox"/> Inner tension 799.2          | <input type="checkbox"/> Painful joints 719.4           |
| <input type="checkbox"/> Thyroid trouble 246.9        | <input type="checkbox"/> Pain in shoulder/arm 719.4       | <input type="checkbox"/> Irritability 799.2           | <input type="checkbox"/> Swollen joints 719.0           |
| <input type="checkbox"/> Twitching of face 351.9      | <input type="checkbox"/> Pins-needles in arm/hand 782.0   | <input type="checkbox"/> Gall bladder trouble 575.9   | <input type="checkbox"/> Pins-needles in leg/foot 782.0 |
| <input type="checkbox"/> Fatigue 780.7                | <input type="checkbox"/> Cold hands/fingers 782.0         | <input type="checkbox"/> Indigestion 536.8            | <input type="checkbox"/> Swollen ankles 782.3           |
| <input type="checkbox"/> Depression 311.0             | <input type="checkbox"/> Tonsillitis 784.0                | <input type="checkbox"/> Intestinal gas 787.3         | <input type="checkbox"/> Cold feet 782.0                |
| <input type="checkbox"/> Dizziness 780.4              | <input type="checkbox"/> Prostate trouble 601.4           | <input type="checkbox"/> Low back pain 724.2          | <input type="checkbox"/> Pain in legs/feet 719.46       |
| <input type="checkbox"/> Spinal curvature 737.43      | <input type="checkbox"/> Bed wetting 788.3                | <input type="checkbox"/> Hernia 550.01                | <input type="checkbox"/> Hip pain 719.45                |
| <input type="checkbox"/> Chest pain 786.5             | <input type="checkbox"/> Stroke 436.0                     |   |   |

Has your child been

immunized?:

Yes  No

If yes, please check all that apply:

- |  |   |
|--|---|
| <input type="checkbox"/> DPT or DTaP (Diphtheria/Pertussis/Tetanus): What age: _____ | <input type="checkbox"/> Varicella Zoster (Chicken pox):<br>What age: _____ |
| <input type="checkbox"/> MMR (Measles/Mumps/Rubella): What age: _____                | <input type="checkbox"/> Hepatitis A: What age: _____                       |
| <input type="checkbox"/> Polio : What age: _____                                     | <input type="checkbox"/> Pneumococcal: What age: _____                      |
| <input type="checkbox"/> HIB (Haemophilus influenza type B): What age: _____         | <input type="checkbox"/> Influenza: What age: _____                         |
| <input type="checkbox"/> HEP-B (Hepatitis B): What age: _____                        |   |

### Family History

Do any of the child's family members have any of the following:

(Name and Age)

- Headaches \_\_\_\_\_
- Allergies \_\_\_\_\_
- Ear infections \_\_\_\_\_
- Frequent colds \_\_\_\_\_
- Asthma \_\_\_\_\_
- Constant Irritability \_\_\_\_\_
- Constipation \_\_\_\_\_
- Growing pains \_\_\_\_\_
- Bloody nose \_\_\_\_\_
- Scoliosis \_\_\_\_\_
- Bedwetting \_\_\_\_\_

Do any of the child's blood relatives have any of the following:

(If yes, what relation to you)

- Diabetes \_\_\_\_\_
- Cancer \_\_\_\_\_
- Stroke \_\_\_\_\_
- Heart Problems \_\_\_\_\_
- Scoliosis \_\_\_\_\_
- Back problems \_\_\_\_\_
- Headaches \_\_\_\_\_
- Ulcers \_\_\_\_\_

### Female Patients Only

To the best of your knowledge, is the patient pregnant, either suspected or confirmed at this particular time?

Yes  No

### PLEASE SIGN!

I CERTIFY THAT THE INFORMATION I HAVE PROVIDED HERE IS TRUE TO THE BEST OF MY KNOWLEDGE. I hereby authorize Dr. Levinson and whomsoever she may designate as her assistants to administer Chiropractic care as she deems necessary to this minor child. I also authorize release of any appropriate information concerning this child's condition to any insurance company, attorney, or adjuster in order to process any claim for reimbursement

X \_\_\_\_\_

Signature of Parent or Guardian

\_\_\_\_\_ Date

## Informed Consent for Chiropractic Care

Patient Name (or Child's Name): \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_  
Parent/Guardian (if minor): \_\_\_\_\_

### 1. Nature of Care

Chiropractic care uses gentle adjustments, soft tissue work, and lifestyle recommendations to improve joint function, relieve discomfort, and support overall health.

### 2. Benefits

- Pain and tension relief
- Improved mobility, posture, and nervous system function
- Support for better overall wellness

*No specific results are guaranteed.*

### 3. Risks

Chiropractic care is generally safe, but possible effects include:

- **Common (temporary):** mild soreness, stiffness, or fatigue.
- **Less common:** muscle or ligament strain, disc irritation, or rib injury.
- **Rare but serious:** stroke or artery injury with neck adjustments, or aggravation of an underlying condition.

Questions are encouraged before care.

### 4. Alternatives

You may choose other care options (medical care, physical therapy, massage) or decline care at any time.

### 5. Health Disclosure

I have shared all relevant health history (e.g., bone conditions, vascular problems, medications, birth history for children). I will inform the doctor of any changes.

### 6. Consent

By signing below, I confirm:

I have read and understood this form.

I have had the chance to ask questions.

I consent to chiropractic care for myself/my child at Levinson Family Chiropractic.

This consent applies to ongoing care unless revoked.

Patient/Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Chiropractor/Witness: \_\_\_\_\_ Date: \_\_\_\_\_