



**Tressler
chiropractic**

**Serving God For
Healthier Generations.**

Date: _____

CHILD APPLICATION SURVEY

Name: _____ (Age) _____ Gender: M F
Home Address: _____ Date of Birth ____/____/____
City, State, Zip: _____ Home Phone: () _____
Parent/Guardian Name: Mother: _____ Father: _____ Marital Status: S M D W
Cell Phone: () _____ Email Address: _____
How were you referred to this office: _____

PURPOSE OF THIS VISIT

Reason for this visit - Main Complaint: _____

1. Research shows that spinal problems often begin at birth. How old was your child when they received this first chiropractic checkup? _____ Never
2. Difficult, long and/or doctor assisted births can cause spinal misalignments. Was your child born by C-section, forceps, suction cup, or other device? _____
3. How long was the actual labor and delivery time? _____
4. Have you ever been told that your child has a spinal curvature, spinal arthritis, or inherited spinal problem?
Yes No _____
5. 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
6. Does your child suffer from any of the following:

<input type="checkbox"/> Acid Reflux	<input type="checkbox"/> Cancer	<input type="checkbox"/> Leg Pain/Cramps
<input type="checkbox"/> Allergies	<input type="checkbox"/> Chronic Lung Infection	<input type="checkbox"/> Recurrent colds/flu
<input type="checkbox"/> Asthma/Wheezing	<input type="checkbox"/> Difficulty Concentrating	<input type="checkbox"/> Sinus Problems
<input type="checkbox"/> Attention Deficit Disorder (ADD)	<input type="checkbox"/> Digestive Disorders	<input type="checkbox"/> Trouble Sleeping
<input type="checkbox"/> Bed Wetting	<input type="checkbox"/> Ear Infections	<input type="checkbox"/> Visual Problems
<input type="checkbox"/> Behavioral issues	<input type="checkbox"/> Headaches	<input type="checkbox"/> Lazy/Cross Eyes
<input type="checkbox"/> Other: _____		
7. Does your child have other health problems that concern you? _____

8. 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? _____
9. 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? _____
10. What sports does your child participate in? _____
11. If the doctor feels that your child will benefit from chiropractic care, are you willing to follow his recommendations?
Yes No

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

Parent/Guardian Signature: _____ Date: _____