

Functional Questionnaire

Patient Name: _____

Date: _____

Daily Activities: Effects of Current conditions On Performance

| | | | | |
|---------------------|------------------------------------|---|---|--|
| Walking | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (Limits) | <input type="checkbox"/> Unable to Perform |
| Standing | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (Limits) | <input type="checkbox"/> Unable to Perform |
| Running | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (Limits) | <input type="checkbox"/> Unable to Perform |
| Pushing | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (Limits) | <input type="checkbox"/> Unable to Perform |
| Reading | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (Limits) | <input type="checkbox"/> Unable to Perform |
| Gardening | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (Limits) | <input type="checkbox"/> Unable to Perform |
| Dancing | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (Limits) | <input type="checkbox"/> Unable to Perform |
| Shoveling | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (Limits) | <input type="checkbox"/> Unable to Perform |
| Sleeping | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (Limits) | <input type="checkbox"/> Unable to Perform |
| Doing Chores | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (Limits) | <input type="checkbox"/> Unable to Perform |
| Rolling Over | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (Limits) | <input type="checkbox"/> Unable to Perform |
| Watching TV | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (Limits) | <input type="checkbox"/> Unable to Perform |
| Playing Sports | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (Limits) | <input type="checkbox"/> Unable to Perform |
| Sitting to Standing | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (Limits) | <input type="checkbox"/> Unable to Perform |
| Doing Computer Work | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (Limits) | <input type="checkbox"/> Unable to Perform |
| Bending | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (Limits) | <input type="checkbox"/> Unable to Perform |
| Lifting | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (Limits) | <input type="checkbox"/> Unable to Perform |
| Carrying | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (Limits) | <input type="checkbox"/> Unable to Perform |
| Dressing | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (Limits) | <input type="checkbox"/> Unable to Perform |
| Sitting | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (Limits) | <input type="checkbox"/> Unable to Perform |
| Working | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (Limits) | <input type="checkbox"/> Unable to Perform |
| Driving | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (Limits) | <input type="checkbox"/> Unable to Perform |

PATIENT DEMOGRAPHICS

Child's Name _____ Today's Date ____/____/____ PtID#: _____

Date of Birth ____/____/____ Birth Height: _____ Birth Weight: _____ Current Height: _____ Current Weight: _____ Age: _____

Address _____ City _____ State _____ Zip _____

Phone (Home) _____ Mothers mobile: _____ Fathers mobile: _____

Mother _____ DOB ____/____/____ Father _____ DOB ____/____/____

Pediatrician/Family MD _____ City & State _____ Last Visit: ____/____/____

Who is responsible for this bill? Father Social Security # _____ - _____ - _____ Mother Social Security # _____ - _____ - _____

Other (please explain): _____

CHILD'S CURRENT PROBLEM:

Purpose of this visit: _____ Wellness Check-up _____ Injury or Accident _____ Other Please explain: _____

If your child is experiencing **pain/discomfort please identify where** _____ **and for how long** _____

- When** did the problem first begin? Date ____/____/____ _____ Unknown _____ Gradual _____ Sudden _____
- Ever had** this problem **before**? No Yes If yes when? _____
- Any **bowel or bladder** problems since this problem began? No Yes (Describe) _____
- Have you seen any **other doctors** for this problem? No Yes If yes, who? _____
- How long ago? _____ Days _____ Weeks _____ Months _____ Years _____
- What were the results of past treatment? _____
- How is this problem **NOW**: Rapidly Improving Slowly Improving About the Same Gradually Worsening On & Off
- Please list any **medication taken** for this problem: _____
- Has your child ever sustained an injury playing sports? _____ If yes, please explain _____
- Has your child ever sustained an injury in an auto accident? _____ if yes, please explain _____

HAS YOUR CHILD EVER SUFFERED FROM: mark a **Y** for YES OR **N** for NO

| | | | | |
|--------------------------|--------------------------|---------------------------|--------------------------|---------------------------------|
| ____ Headaches | ____ Orthopedic Problems | ____ Digestive Disorders | ____ Behavioral Problems | ____ Fall From Changing Table |
| ____ Neck Problems | ____ Poor Appetite | ____ ADD/ADHD | ____ Fainting | ____ Fall Off Skateboard/Skates |
| ____ Stomach Aches | ____ Ruptures/Hernia | ____ Seizures/Convulsions | ____ Leg Problems | ____ Fall From Bed or Couch |
| ____ Muscle Pain | ____ Heart Trouble | ____ Joint Problems | ____ Constipation | ____ Fall Off Monkey Bars |
| ____ Chronic Earaches | ____ Backaches | ____ Diarrhea | ____ Sinus Trouble | ____ Fall From High Chair |
| ____ Hypertension | ____ Asthma | ____ Scoliosis | ____ Anemia | ____ Arm Problems |
| ____ Walking Trouble | ____ Bed Wetting | ____ Colic | ____ Broken Bones | ____ Dizziness |
| ____ Fall In Baby Walker | ____ Fall From Crib | ____ Fall Off Swing | ____ Fall Off Bicycle | ____ Growing Pains |
| ____ Fall Downstairs | ____ Fall Off Slide | ____ Sleeping Problems | ____ Colds/Flu | ____ Poor Posture |
| ____ Reflux | ____ Allergies to _____ | ____ Other: _____ | | |

I understand that I am directly and fully responsible to Trinity Chiropractic for all fees associated with chiropractic care my child receives. It has been explained to me that all fees paid for x-rays taken at this office are for the examination and that I am only entitled to a copy of the written imaging report, which explains the results of my child's examination. The actual films themselves are considered part of my child's original health record and as such will not be released to anyone, under any circumstances, including me. I further understand and agree that the actual films are **the sole legal property** of Trinity Chiropractic and that by law, the doctor must retain these films for a period of no less than 7 years.

The risks associated with exposure to ionization, and spinal adjustments have been explained to me to my complete satisfaction, and I have conveyed my understanding of these risks to the doctor. After careful consideration I do hereby request, and authorize imaging studies, and chiropractic adjustments, for the benefit of my minor child, for whom I have the legal right to select, and authorize health care services on behalf of.

Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse /former spouse or other guardian is not required. If my authority to so select and authorize this care should change in any way, I will immediately notify this office.

Parent or Legal Guardian's Signature

Date