KNIGHT *Family* CHIROPRACTIC

PEDIATRIC OUTCOME ASSESSMENT

Patient Name_________________________________ Date____________________

NO SYMPTOMS ——————————————————————————————— EXTREME SYMPTOMS

Please place an "X" on the line above to indicate your child's level of problem.

1. What was the chief symptom or reason you brought your child to our clinic? ____________
   ____

2. How do you classify your child's improvement so far since beginning their care?
   Excellent _________ Good_________ Fair_________ Poor_________

3. Rate your child's improvement on a scale of 1 to 10, with 10 being the best:____________

4. Which of the following symptoms have improved for your child?
   - ❑ Colic/Frequent Crying ❑ Reflux ❑ Constipation ❑ Ear Infections
   - ❑ Sleeping Problems ❑ Allergies ❑ Headaches ❑ Bed Wetting
   - ❑ Head Rotation/Torticollis ❑ Asthma ❑ Leg Pain ❑ Posture
   - ❑ Latching/Breast Feeding Difficulty ❑ Learning Difficulties/ADHD
   - ❑ Other(s):____

5. Which of the following symptoms does your child still have?
   - ❑ Colic/Frequent Crying ❑ Reflux ❑ Constipation ❑ Ear Infections
   - ❑ Sleeping Problems ❑ Allergies ❑ Headaches ❑ Bed Wetting
   - ❑ Head Rotation/Torticollis ❑ Asthma ❑ Leg Pain ❑ Poor Posture
   - ❑ Latching/Breast Feeding Difficulty ❑ Learning Difficulties/ADHD
   - ❑ Other(s):____

6. What is easier for your child to do now?
   ❑ Sit ❑Crawl ❑ Walk ❑ Sleep ❑ Eat/Feed ❑ Sports ❑ School

7. Is there any confusion or question(s) about any phase of your child's progress or other condition(s) your child has that we have not discussed that you would like to discuss at this time? ______ If yes, please explain:______________________________________
   ____

8. For Wellness Care for your child, would you prefer:
   _____ 1 time per week _____ 2 times per month _____ 1 time per month

X____

Parent/Legal Guardian Signature