

Pediatric Patient Questionnaire

CONFIDENTIAL PATIENT INFORMATION

Child's Name:	Parent/Guardian Name(s):		
Street Address:	City, State, Postal Code:		
Cell Phone:	Other Phone:	Child's Sex: <input type="radio"/> M <input type="radio"/> F	
Email:	Child's SS #:	Birthdate:	Age:
How did you hear about us?	Weight:	Height:	
Who is your primary care physician?			
Is your child receiving care from any other health professionals? <input type="radio"/> Yes <input type="radio"/> No - If yes, please name them and their specialty:			
Please list any drugs/medications/vitamins/herbs/other that your child is taking:			

CURRENT HEALTH CONDITIONS

What health condition(s) bring your child to be evaluated by a chiropractor?

When did the condition first begin? How did the problem start? Suddenly Gradually Post-Injury

Has your child ever received care for this condition before? Yes No
- If yes, please explain:

Is this condition: Getting worse Improving Intermittent Constant Unsure

What makes the problem better? What makes the problem worse?

HEALTH GOALS FOR YOUR CHILD

What are your top three health goals for your child:

1. _____

2. _____

3. _____

What would you like to gain from chiropractic care?

Resolve existing condition

Overall wellness

Both

Have you ever visited a chiropractor? Yes No If yes, what is their name?

What is their specialty? Pain Relief Physical Therapy & Rehab Nutritional Subluxation-based Other: _____

PREGNANCY & FERTILITY HISTORY

Please tell us about your pregnancy

Any fertility issues? Yes No If yes, please explain:

Did mother smoke? Yes No If yes, how many per week?

Did mother drink? Yes No If yes, how many per week?

Did mother exercise? Yes No If yes, please explain:

Was mother ill? Yes No If yes, please explain:

Any ultrasounds? Yes No If yes, please explain:

Please explain any notable episodes of mental or physical stress during your pregnancy:

Please explain any other concerns or notable remarks about your child's conception or pregnancy:

LABOR & DELIVERY HISTORY

Child's birth was: Natural vaginal birth Scheduled C-section Emergency C-section At how many week's was your child born? _____

Child's birth was: At home At a birthing center At a hospital Other: _____ Doctor/Obstetrician's Name: _____

Please check any applicable interventions or complications:

Breech Induction Pain meds Epidural Episiotomy Vacuum extraction Forceps Other: _____

Please describe any other concerns or notable remarks about your child's labor and/or delivery.

Child's birth weight: _____ Child's birth height: _____ APGAR score at birth: _____ APGAR score after 5 minutes: _____

GROWTH & DEVELOPMENT HISTORY

Is/was your child breastfed? Yes No If yes, how long? _____ Difficulty with breastfeeding? Yes No

Did they ever use formula? Yes No If yes, at what age? _____ If yes, what type? _____

Did/does your child ever suffer from colic, reflux, or constipation as an infant? Yes No

- If yes, please explain:

Did/does your child frequently arch their neck/back, feel stiff, or bang their head? Yes No

- If yes, please explain:

At what age did the child: Respond to sound: _____ Follow an object: _____ Hold their head up: _____ Vocalize: _____ Teethe: _____
Sit alone: _____ Crawl: _____ Walk: _____ Begin cow's milk: _____ Begin solid foods: _____

Please list any food intolerance or allergies, and when they began:

Please list your child's hospitalization and surgical history, including the year:

Please list any major injuries, accidents, falls and/or fractures your child has sustained in his/her lifetime, including the year:

Have you chosen to vaccinate your child? No Yes, on a delayed or selective schedule Yes, on schedule

- If yes, please list any vaccination reactions:

Has your child received any antibiotics? Yes No

- If yes, how many times and list reason:

Night terrors or difficulty sleeping? Yes No If yes, please explain:

Behavioral, social or emotional issues? Yes No If yes, please explain:

How many hours per day does your child typically spend watching a TV, computer, tablet or phone?

How would you describe your child's diet? Mostly whole, organic foods Pretty average High amount of processed foods

ACKNOWLEDGEMENT & CONSENT

Patient Signature: _____

Date: _____