# Pediatric Patient Questionnaire

## CONFIDENTIAL PATIENT INFORMATION

Child's Name: Parent/Guardian Name(s):

Street Address: City: State: Zip:

Cell Phone: - - Home Phone: - - Work Phone: - -

Email: Child's SS #: - - Birthdate: / / Age:

How did you hear about us? Height: ft. in. Weight: lbs.

Who is your primary care physician?

Is your child receiving care from any other health professionals? ◯ Yes ◯ 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: lbs. oz. Child's birth height: in. 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: / /

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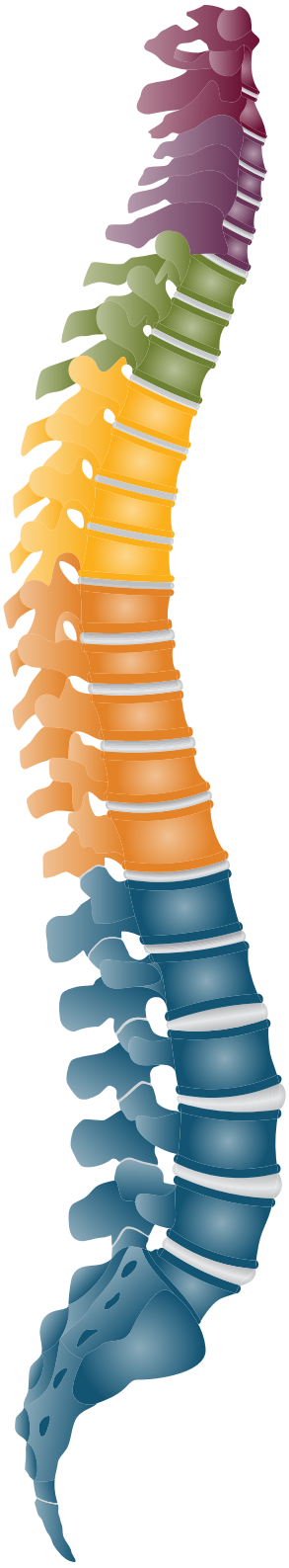
# Patient Review of Systems

THE NERVOUS SYSTEM CONTROLS AND COORDINATES ALL ORGANS AND STRUCTURES OF THE HUMAN BODY

*Please check the corresponding boxes for each symptom or condition you have experienced – including both past and present.*



| REGIONS | FUNCTIONS | SYMPTOMS | | | |
|---|---|---|---|---|---|
| | | PAST | PRESENT | PAST | PRESENT |
| **Cervical** | • Autonomic Nervous System<br>• ENT System<br>• Vision, Balance & Coordination<br>• Speech<br>• Immune System<br>• Digestive System<br>• Nerve Supply to Shoulders, Arms & Hands<br>• Sympathetic Nucleus<br>• Metabolism | ☐ | ☐ Colic & Excessive Crying | ☐ | ☐ Epilepsy & Seizures |
| | | ☐ | ☐ Ear & Sinus Infections | ☐ | ☐ Sensory & Spectrum |
| | | ☐ | ☐ Allergies & Congestion | ☐ | ☐ ADD / ADHD |
| | | ☐ | ☐ Immune Deficiency | ☐ | ☐ Focus & Memory Issues |
| | | ☐ | ☐ Headaches & Migraines | ☐ | ☐ Anxiety & Stress |
| | | ☐ | ☐ Vertigo & Dizziness | ☐ | ☐ Balance & Coordination |
| | | ☐ | ☐ Sore Throat & Strep | ☐ | ☐ Speech Issues |
| | | ☐ | ☐ Swollen Tonsils & Adenoids | ☐ | ☐ TMJ / Jaw Pain |
| | | ☐ | ☐ Vision & Hearing Issues | ☐ | ☐ Stiff Neck & Shoulders |
| | | ☐ | ☐ Low Energy & Fatigue | ☐ | ☐ Depression |
| | | ☐ | ☐ Difficulty Sleeping | ☐ | ☐ High Blood Pressure |
| | | ☐ | ☐ Pain, Numbness & Tingling in Arms to Hands | ☐ | ☐ Poor Metabolism & Weight Control |
| **Upper Thoracic** | • Upper G.I.<br>• Respiratory System<br>• Cardiac Function | ☐ | ☐ Reflux / GERD | ☐ | ☐ Bronchitis & Pneumonia |
| | | ☐ | ☐ Chronic Colds & Cough | ☐ | ☐ Functional Heart Conditions |
| | | ☐ | ☐ Asthma | | |
| **Mid Thoracic** | • Major Digestive Center<br>• Detox & Immunity | ☐ | ☐ Gallbladder Pain / Issues | ☐ | ☐ Indigestion & Heartburn |
| | | ☐ | ☐ Jaundice | ☐ | ☐ Stomach Pains & Ulcers |
| | | ☐ | ☐ Fever | ☐ | ☐ Blood Sugar Problems |
| **Lower Thoracic** | • Stress Response<br>• Filtration & Elimination<br>• Gut & Digestion<br>• Hormonal Control | ☐ | ☐ Behavior Issues | ☐ | ☐ Allergies & Eczema |
| | | ☐ | ☐ Hyperactivity | ☐ | ☐ Skin Conditions / Rash |
| | | ☐ | ☐ Chronic Fatigue | ☐ | ☐ Kidney Problems |
| | | ☐ | ☐ Chronic Stress | ☐ | ☐ Gas Pain & Bloating |
| **Lumbar, Sacrum & Pelvis** | • Lower G.I. (Absorption & Motility)<br>• Gut-Immune System<br>• Major Hormonal Control | ☐ | ☐ Constipation | ☐ | ☐ Sciatica & Radiating Pain |
| | | ☐ | ☐ Chrohn's, Colitis & IBS | ☐ | ☐ Lumbopelvic / SI Joint Pain |
| | | ☐ | ☐ Diarrhea | ☐ | ☐ Hamstring Tightness |
| | | ☐ | ☐ Bed-wetting | ☐ | ☐ Disc Degeneration |
| | | ☐ | ☐ Bladder & Urination Issues | ☐ | ☐ Leg Weakness & Cramps |
| | | ☐ | ☐ Cramps & Menstrual Issues | ☐ | ☐ Poor Circulation & Cold Feet |
| | | ☐ | ☐ Cysts & Endometriosis | ☐ | ☐ Knee, Ankle & Foot Pain |
| | | ☐ | ☐ Infertility | ☐ | ☐ Weak Ankles & Arches |
| | | ☐ | ☐ Impotency | ☐ | ☐ Lower Back Pain |
| | | ☐ | ☐ Hemorrhoids | ☐ | ☐ Gluten & Casein Intolerance |

Patient Name: _____ Date: ___/___/___