

# 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? <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:	What would you like to gain from chiropractic care?
1. _____	<input type="radio"/> Resolve existing condition
2. _____	<input type="radio"/> Overall wellness
3. _____	<input type="radio"/> Both
Have you ever visited a chiropractor? <input type="radio"/> Yes <input type="radio"/> No If yes, what is their name?	
What is their specialty? <input type="radio"/> Pain Relief <input type="radio"/> Physical Therapy & Rehab <input type="radio"/> Nutritional <input type="radio"/> Subluxation-based <input type="radio"/> 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

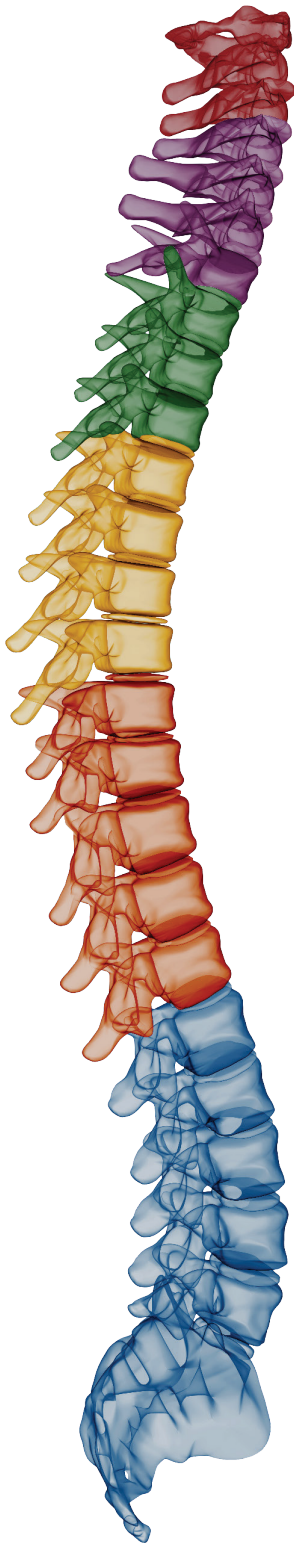
Patient Signature: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

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

Patient Name: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_