Pediatric Patient Questionnaire

CONFIDENTIAL P	ATIENT INFO	RMATION						
Child's Name:		F	Parent/Guardian N	Jame(s):				
Street Address:		(City, State, Zip:					
Cell Phone:		(Other Phone:			Child's Sex:	O M	O F
Email:		(Thild's SS #:			Birthdate:		Age:
How did you hear abou	ıt us?					Weight:		Height:
Who is your primary ca	re physician?							
Is your child receiving c	***		ls? O Yes O N	0				
- If yes, please name th			vous child is talifa					
Please list any drugs/m	iedications/vitamii	ns/nerbs/otner that '	your child is taking	g:				
CURRENT HEALT			1:			为主,从 了		
What health condition(s) bring your child	to be evaluated by	a chiropractor?					
When did the condition	n first begin?		How	did the probl	em start? O Sudo	lenly O Gradu	ally OP	ost-Injury
Has your child ever rece - If yes, please explain:	eived care for this	condition before?	Yes No					
Is this condition: O Ge	etting worse	Improving O Inter	mittent O Cons	tant Uns	ure			
What makes the proble	em better?			What makes	the problem worse	?		
	A 1							
HEALTH GOALS E	OR VOLIR CH	III D						
HEALTH GOALS F					What would yo	ou like to gain fi	rom chiro	practic care?
HEALTH GOALS F What are your top thre					What would yo	ou like to gain fo		practic care?
THE RESERVE TO STREET, SALES OF THE PARTY OF						xisting conditio		practic care?
What are your top thro	ee health goals fo	r your child:			Resolve e	xisting conditio		practic care?
What are your top thro 1 2 3. Have you ever visited a	ee health goals fo	r your child: Yes O No If yes			Resolve e Overall we Both	xisting conditio		practic care?
What are your top thro	ee health goals fo	r your child: Yes O No If yes			Resolve e	xisting conditio		practic care?
What are your top three 1. 2. 3. Have you ever visited a What is their specialty? PREGNANCY & F	ee health goals for a chiropractor? Con Pain Relief	Yes No If ye			Resolve e Overall we Both	xisting conditio		practic care?
What are your top thro 1 2 3. Have you ever visited a What is their specialty?	ee health goals for a chiropractor? O Pain Relief ERTILITY HIS pur pregnancy	Yes No If yes Physical Therap	y & Rehab O N		Resolve e Overall we Both	xisting conditio		practic care?
What are your top three 1. 2. 3. Have you ever visited a What is their specialty? PREGNANCY & F	ee health goals for a chiropractor? O Pain Relief ERTILITY HIS pur pregnancy	Yes No If ye	y & Rehab O N		Resolve e Overall we Both	xisting conditio		practic care?
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What are your top thro 1. 2. 3. Have you ever visited a What is their specialty? PREGNANCY & F Please tell us about you have fertility issues?	ee health goals for a chiropractor? Pain Relief ERTILITY HIS our pregnancy Yes No	Yes No If yes Physical Therapy TORY If yes, please explain	y & Rehab O N n: er week?		Resolve e Overall we Both	xisting conditio		practic care?
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LABOR & DELIVERY HISTORY	
Child's birth was: Natural vaginal birth Scheduled C-section Emergency C-section	ection 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 extracti	ion Forceps Other
Please describe any other concerns or notable remarks about your child's labor and/or delive	ery.
Child's birth weight: APGAR score at birth:	APGAR score after 5 minutes:
GROWTH & DEVELOPMENT HISTORY	
Is/was your child breastfed?	Difficulty with breastfeeding?
Did they ever use formula?	If yes, what type?
Did/does your child ever suffer from colic, reflux, or constipation as an infant? Yes Yes If yes, please explain:	No
Did/does your child frequently arch their neck/back, feel stiff, or bang their head?	⊃ No
At what age did the child: Respond to sound: Follow an object: Hold the Sit alone: Crawl: Walk: Begin cow'	•
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/h	ner lifetime, including the year:
Have you chosen to vaccinate your child?	edule 🔾 Yes, on schedule
Has your child received any antibiotics? • Yes • No • If yes, how many times and list reason:	
Night terrors or difficulty sleeping?	
Behavioral, social or emotional issues?	
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? O Mostly whole, organic foods O Pretty avera	ge O High amount of processed foods
ACKNOWLEDGMENT & CONSENT	
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Patient Signature:	Date: