

Pediatric Patient Questionnaire

CONFIDENTIAL PATIENT INFORMATION

Child's Name:	Parent/Guardian Name:	Age:	DOB:
Street Address:			
City:	State:	Zip Code:	
Email:	Cell Phone:		
Emergency Contact:	Relation:	Phone:	
How Did you hear about us?			
Date & Reason for last doctor visit?			
Is your child receiving care from any health care providers? Yes No			
-if yes, please name them & their specialty			

TOP 3 HEALTH GOALS FOR YOUR CHILD

1.
2.
3.

CURRENT HEALTH CONDITIONS

What health conditions bring your child into our office?
Has your child received care for this problem before? Yes No
When did the condition(s) first begin?
What would you like to gain from chiropractic care? Resolve Existing Condition Overall Wellness Both

CHIROPRACTIC HISTORY

Has your child ever visited a chiropractor? Yes No If yes, what is their name?
What is their specialty? Pain Relief Physical Therapy & Rehab Pediatric Subluxation Based Other
When was their last adjustment?
How often were they getting adjusted?

PREGNANCY & FERTILITY HISTORY

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
born at how many weeks?

Child's birth was: At home At birthing center At hospital Other

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.

GROWTH & DEVELOPMENT HISTORY

Is/was your child breastfed? Yes No If yes, how long? If yes, are they still?
Difficulty with breastfeeding? Yes No If yes, please explain

Did they ever use formula? Yes No If yes, at what age? If yes, are they still?

Did/Does your child suffer from colic, reflux and/or constipation as an infant? Yes No
If yes please explain:

Did/Does your child frequently arch their neck/back, feel stiff? Yes No

Please list any hospitalizations, surgeries, major accidents, falls and/or fractures your child has sustained in his/her life:

Have you chosen to vaccinate your child? No Yes, on delayed or selective schedule Yes, on schedule
If yes, list any vaccine reactions:

Night terrors or difficulty sleeping? Yes No

If yes, please explain:

Behavioral, social or emotional challenges? Yes No

If yes, please explain:



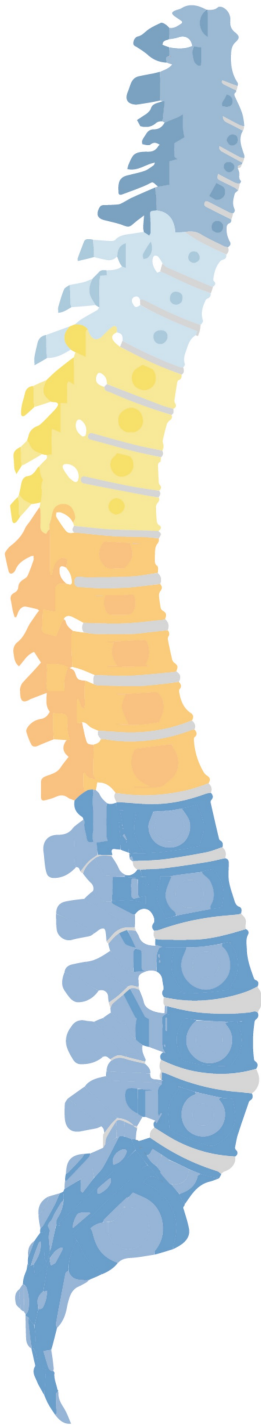
Patient Review of Symptoms

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

REGIONS

FUNCTIONS

SYMPTOMS



CERVICAL

- Autonomic Nervous System
- ENT System
- Vision, Balance & Coordination
- Speech
- Immune System
- Digestive System
- Nerve Supply to Shoulders, Arms & Hands
- Sympathetic Nucleus
- Metabolism

- ☐ Colic & Excessive Crying
- ☐ Ear & Sinus Infections
- ☐ Allergies & Congestion
- ☐ Immune Deficiency
- ☐ Headaches & Migraines
- ☐ Vertigo & Dizziness
- ☐ Sore Throat & Strep
- ☐ Swollen Tonsils & Adenoids
- ☐ Vision & Hearing Issues
- ☐ Low Energy & Fatigue
- ☐ Difficulty Sleeping
- ☐ Pain, Numbness & Tingling in Arms to Hands

- ☐ Epilepsy & Seizures
- ☐ Sensory & Spectrum
- ☐ ADD / ADHD
- ☐ Focus & Memory Issues
- ☐ Anxiety & Stress
- ☐ Balance & Coordination
- ☐ Speech Issues
- ☐ TMJ / Jaw Pain
- ☐ Stiff Neck & Shoulders
- ☐ Depression
- ☐ High Blood Pressure
- ☐ Poor Metabolism & Weight Control

UPPER THORACIC

- Upper G.I.
- Respiratory System
- Cardiac Function

- ☐ Reflux / GERD
- ☐ Chronic Colds & Cough
- ☐ Asthma

- ☐ Bronchitis & Pneumonia
- ☐ Functional Heart Conditions

MID THORACIC

- Major Digestive Center
- Detox & Immunity

- ☐ Gallbladder Pain / Issues
- ☐ Jaundice
- ☐ Fever

- ☐ Indigestion & Heartburn
- ☐ Stomach Pains & Ulcers
- ☐ Blood Sugar Problems

LOWER THORACIC

- Stress Response
- Filtration & Elimination
- Gut & Digestion
- Hormonal Control

- ☐ Behavior Issues
- ☐ Hyperactivity
- ☐ Chronic Fatigue
- ☐ Chronic Stress

- ☐ Allergies & Eczema
- ☐ Skin Conditions / Rash
- ☐ Kidney Problems
- ☐ Gas Pain & Bloating

LUMBAR

- Lower G.I. (Absorption & Motility)
- Gut-Immune System
- Major Hormonal Control

- ☐ Constipation
- ☐ Crohn's, Colitis & IBS
- ☐ Diarrhea
- ☐ Bed-wetting
- ☐ Bladder & Urination Issues
- ☐ Cramps & Menstrual Issues
- ☐ Cysts & Endometriosis
- ☐ Infertility
- ☐ Impotency
- ☐ Hemorrhoids

- ☐ Sciatica & Radiating Pain
- ☐ Lumbopelvic / SI Joint Pain
- ☐ Hamstring Tightness
- ☐ Disc Degeneration
- ☐ Leg Weakness & Cramps
- ☐ Poor Circulation & Cold Feet
- ☐ Knee, Ankle & Foot Pain
- ☐ Weak Ankles & Arches
- ☐ Lower Back Pain
- ☐ Gluten & Casein Intolerance

Informed Consent for Chiropractic Care

I hereby request and consent to the performance of chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working with, or associated with or serving as back-up for the doctor of chiropractic named below, including those working at other Chiropractic Partners offices.

I have had an opportunity to discuss with the doctor of chiropractic named below, and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed. I understand and am informed that, as with the practice of medicine chiropractic carries some risks to treatment, including, but not limited to fractures, disc injuries, strokes, dislocations and sprains.

I do not expect the doctor to be able to anticipate and explain all risks and complications. I consent to rely on the doctor's best judgment, exercised during the course of treatment that is in my best interest, based upon the known facts. I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its consent, and by signing below I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my present condition(s) and for any future condition(s) for which I seek treatment.

Patient Name (Printed)

Date Signed

Signature: Patient or Legal Representative (Attorney, Guardian, Parent)

Witness to Signature

Doctor of Chiropractic Signature

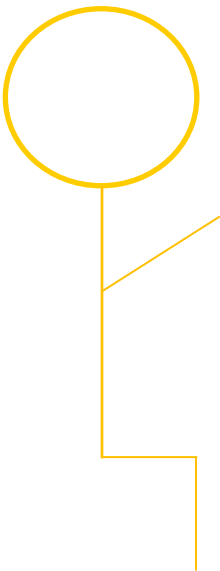
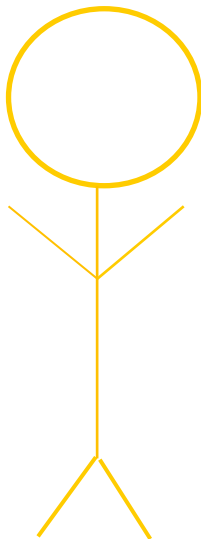
Date Signed

Doctor's Use Only

AGE: ____

PRIOR DC

Y N



PREGNANCY/BIRTH

EATING

SLEEPING

DIGESTION

GOALS

MOTOR SKILLS

IMMUNE

OTHER

SURGERIES/INJURIES
