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?

Abundant Life CHIROPRACTIC

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

Childs 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

CERVICAL

FUNCTIONS

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

SYMPTOMS

- ☐ 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

FUNCTIONS

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

SYMPTOMS

- ☐ Reflux / GERD
- ☐ Chronic Colds & Cough
- ☐ Asthma
- ☐ Bronchitis & Pneumonia
- ☐ Functional Heart Conditions

MID THORACIC

FUNCTIONS

- Major Digestive Center
- Detox & Immunity

SYMPTOMS

- ☐ Gallbladder Pain / Issues
- ☐ Jaundice
- ☐ Fever
- ☐ Indigestion & Heartburn
- ☐ Stomach Pains & Ulcers
- ☐ Blood Sugar Problems

LOWER THORACIC

FUNCTIONS

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

SYMPTOMS

- ☐ Behavior Issues
- ☐ Hyperactivity
- ☐ Chronic Fatigue
- ☐ Chronic Stress
- ☐ Allergies & Eczema
- ☐ Skin Conditions / Rash
- ☐ Kidney Problems
- ☐ Gas Pain & Bloating

LUMBAR

FUNCTIONS

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

SYMPTOMS

- ☐ Constipation
- ☐ Chrohn'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

Abundant Life CHIROPRACTIC

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 conditions(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

_____ _____

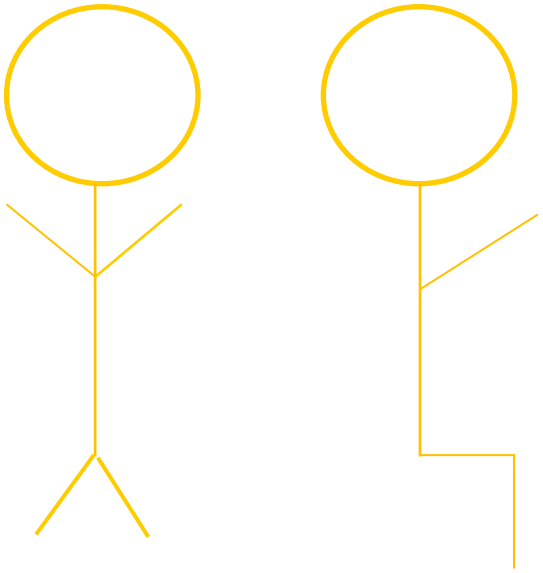
Doctor of Chiropractic Signature Date Signed

Doctor's Use Only

AGE: ___

PRIOR DC

Y N



PREGNANCY/BIRTH

EATING

SLEEPING

DIGESTION

GOALS

MOTOR SKILLS

IMMUNE

OTHER

SURGERIES/INJURIES