Pediatric Patient Questionnaire

CONFIDENTIAL PATIENT INFORMATION

Child's Name:	Parent/Guardian Name:	Age:	DOB:
Street Address:		Gender:	
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

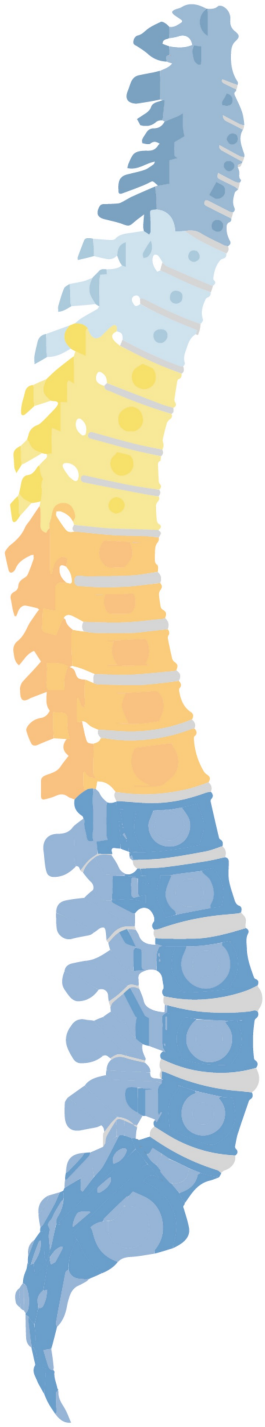
If yes, please explain:

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.

Photo Consent

We are a photo taking office. We love capturing and sharing all the fun and exciting moments we have in the office and would love to include you and your little one!

I hereby authorize Abundant Life Chiropractic to use my testimonial and any information contained herein, including photos and video, in its public relation efforts. I understand and approve the disclosure of testimonial information, photos and video to the media, social media and other individuals and entities that may be involved in the public relations efforts of Abundant Life Chiropractic, including but not limited to Abundant Life Chiropractic's Facebook page, Instagram page, and in-office displays. By signing below I agree and acknowledge that I have read and understood the above and Release, have had the opportunity to ask questions about it, and agree to all terms described. (please check the box that applies)

☐ Yes, I consent to take and use photos of my child and self

☐ No, I do not consent to photos of my child and self

_____ _____

Patient Name (Printed) Date Signed

_____ _____

Parent/Legal Guardian Name (Printed) Witness to Signature

_____ _____

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

_____

Doctor of Chiropractic Signature

Doctor's Use Only

AGE: ___

PRIOR DC

Y N

ROF:

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_____

PREGNANCY/BIRTH

EATING

SLEEPING

DIGESTION

GOALS

MOTOR SKILLS

IMMUNE

OTHER

SURGERIES/INJURIES