

Pediatric Patient Questionnaire

CONFIDENTIAL PATIENT INFORMATION

Child's Name:	Parent/Guardian Name(s):		
Street Address:	City, State, Zip:		
Cell Phone:	Other Phone:	Child's Sex: <input type="radio"/> M <input type="radio"/> F	
Email:	Child's SS #:	Birthdate:	Age:
How did you hear about us?		Weight:	Height:
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? <input type="radio"/> Suddenly <input type="radio"/> Gradually <input type="radio"/> Post-Injury
Has your child ever received care for this condition before? <input type="radio"/> Yes <input type="radio"/> No - If yes, please explain:	
Is this condition: <input type="radio"/> Getting worse <input type="radio"/> Improving <input type="radio"/> Intermittent <input type="radio"/> Constant <input type="radio"/> 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?	<input type="radio"/> Yes <input type="radio"/> No	If yes, please explain:
Did mother smoke?	<input type="radio"/> Yes <input type="radio"/> No	If yes, how many per week?
Did mother drink?	<input type="radio"/> Yes <input type="radio"/> No	If yes, how many per week?
Did mother exercise?	<input type="radio"/> Yes <input type="radio"/> No	If yes, please explain:
Was mother ill?	<input type="radio"/> Yes <input type="radio"/> No	If yes, please explain:
Any ultrasounds?	<input type="radio"/> Yes <input type="radio"/> 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: _____ Child's birth height: _____ 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

ACKNOWLEDGMENT & CONSENT

Patient Signature: _____ Date: _____