Pediatric Health Questionnaire

Account # ________________

Patient Name____ Today's Date: ________________________

Referred by________________________________ Date of Birth: ____/____/____ Age: ____________ Gender: M / F

Street Address: ____

City: ____________________________________ State: _____________ Zip Code: ____________________

Parent/Guardian 1: ____

Preferred Phone # (_____) ______-_______ E-Mail address: ____

Parent/Guardian 2: ____

Preferred Phone # (_____) _____-________ E-Mail address: ____

Insurance Co__________________________ Policy Holder Name_____________________ Policy Holder DOB__________

Consent for Treatment of a Minor

I hereby authorize Dr. Tagliarini and whomever he/she may designate as assistants to administer examinations and Chiropractic care as deemed necessary to my child.

Parent or Guardian's Name (printed): ____

Parent or Guardian's Signature: ____

Please provide the names of any of your child's healthcare providers that we have permission to share medical records with:

Pediatrician ____ Midwife/OB _______________________________

Lactation consultant ___________________________________ Other ____________________________________

Parent/Guardian 1 Signature: ____________________________

Parent/Guardian 2 Signature: ____________________________

1. Describe your child's current symptoms :

____

____

____

2. How long? ____ 3. How frequent? ________________________

4. What treatments have you tried for current symptoms? ____

5. What makes symptoms better? ____

6. What makes it worse? ____

7. Goals of care?____

7. Birth History: ***(check all that apply)***

- ☐ Born on time ?
- ☐ Born Early? How Early? ___________
- ☐ Born past due? How late? _________
- ☐ Went into labor naturally
- ☐ Medically induced labor
- ☐ Pitocin used
- ☐ Water broke naturally
- ☐ Water broken by doctor
- ☐ Vaginal birth - location:___________
- ☐ Scheduled cesarean
- ☐ Emergency cesarean
- ☐ Epidural used
- ☐ Forceps Used
- ☐ Vacuum extraction used
- ☐ Umbilical cord around neck
- ☐ How long did mom push?__________
- ☐ Other__________________________

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8. Feeding History: ***(check all that apply)***

- ☐ Nursed? How long? ________
- ☐ Pumping currently
- ☐ Formula fed
- ☐ Tongue / lip tie (CIRCLE)
- ☐ Difficulty nursing / latching (CIRCLE)
- ☐ Lactation consultant utilized

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9. Other History: ***(check all that apply)***

- ☐ Frequent ear infections
- ☐ Frequent Illness (cold/sick)
- ☐ Frequent fevers
- ☐ RSV
- ☐ Antibiotic Use
- ☐ Tonsillitis
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive gassiness
- ☐ Excessive spit up
- ☐ Colic
- ☐ Reflux
- ☐ Torticollis
- ☐ Overall body tension
- ☐ Motor / speech delays (CIRCLE)
- ☐ Frequent crying spells
- ☐ Sleeping problems
- ☐ Scoliosis
- ☐ Allergies / Asthma (CIRCLE)
- ☐ Headaches
- ☐ Growing pains
- ☐ Bedwetting
- ☐ ADD / ADHD
- ☐ Up to date on vaccines

***10.* Pediatrician:** ___________________________________ ***11.* Date of Last Medical Physical**___________________________

12. Indicate if an immediate family member has had any of the following:

(1) Rheumatoid Arthritis (2) Heart Problems (3) Diabetes (4) Cancer (5) Lupus (6) Other: __________

13. List all prescription and over-the-counter medications, nutritional/herbal supplements your child is taking:

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14. List all the times your child has been hospitalized & all surgeries:

____

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15. <u>ANY & ALL</u> LIFETIME TRAUMA HISTORY to head, neck, or back (such as concussion, automobile accident, sports injury, etc.)...EVEN IF YOUR CHILD DID NOT HAVE ANY SYMPTOMS OR TREATMENT WITH THIS TRAUMA, STILL NOTE IT PLEASE.

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Parent/Guardian Signature____ ***Date***__________________________