

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. Birth History: (check all that apply)

- | | | |
|---|---|---|
| <input type="checkbox"/> Born premature? How Early? _____ | <input type="checkbox"/> Vaginal birth at home | <input type="checkbox"/> Emergency cesarean |
| <input type="checkbox"/> Born on time ? | <input type="checkbox"/> Vaginal birth at Hospital | <input type="checkbox"/> Epidural used |
| <input type="checkbox"/> Born past due? How late? _____ | <input type="checkbox"/> Vaginal birth at birthing center | <input type="checkbox"/> Forceps Used |
| <input type="checkbox"/> Induced labor | <input type="checkbox"/> Scheduled cesarean | <input type="checkbox"/> Vacuum extraction used |
-

8. Feeding History: (check all that apply)

- | | | |
|--|--------------------------------------|---|
| <input type="checkbox"/> Nursed? How long? _____ | <input type="checkbox"/> Both? | <input type="checkbox"/> Lip tie? |
| <input type="checkbox"/> Formula fed? | <input type="checkbox"/> Tongue tie? | <input type="checkbox"/> Lactation consultant used? |
-

9. Other History: (check all that apply)

- | | | |
|---|---|--|
| <input type="checkbox"/> ADD/ ADHD | <input type="checkbox"/> Frequent fevers | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Frequent ear infections | <input type="checkbox"/> Sleeping problems | <input type="checkbox"/> Growing pains |
| <input type="checkbox"/> Constipation/Diarrhea | <input type="checkbox"/> Antibiotic Use | <input type="checkbox"/> Bed-wetting |
| <input type="checkbox"/> RSV | <input type="checkbox"/> Tonsillitis | <input type="checkbox"/> Up to date on vaccines |
| <input type="checkbox"/> Motor or speech delays | <input type="checkbox"/> Colic | <input type="checkbox"/> Modified/Delayed vaccine schedule |
| <input type="checkbox"/> Frequent Illness (cold/sick) | <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Medical vaccine exemption |
| <input type="checkbox"/> Frequent crying spells | <input type="checkbox"/> Allergies / Asthma | <input type="checkbox"/> Religious vaccine exemption |
-

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:

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

15. ANY & ALL 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.

Parent/Guardian Signature _____ **Date** _____