Pediatric Patient Questionnaire

Confidential Patient Information

Child's Name:
Parent/Guardian Name(s):

Street Address:
City, State, Postal Code:

Cell Phone:
Other Phone:
Child's Sex:

Email:
Child's SSN:
Birthdate:
Age:

How did you hear about us?
Height:
Weight:

Who is your primary care physician?

Is your child receiving care from any other health professionals? ○ Yes ○ No
– If yes, please name them and their specialty:

Please list any drugs/medications/vitamins/herbs or 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? ○ Suddenly ○ Gradually ○ Post-Injury

Has your child ever received care for this condition? ○ Yes ○ No
– If yes, please explain:

Is this condition: ○ Getting worse ○ Improving ○ Intermittent ○ Constant ○ 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?

1. ______________________________
2. ______________________________
3. ______________________________

What would you like to gain?

○ Resolve existing condition
○ Overall wellness
○ Both

Has your child ever visited a chiropractor? ○ Yes ○ No
– If yes, what is their name:

– What is their specialty: ○ Pain Relief ○ Physical Therapy & Rehab ○ Nutrition ○ Subluxation-based ○ Other:

Pregnancy & Fertility History

Please tell us about your pregnancy:

Any fertility issues? ○ Yes ○ No If yes, please explain: ______________________________
Did mother smoke? ○ Yes ○ No If yes, how often? ______________________________
Did mother drink? ○ Yes ○ No If yes, how often? ______________________________
Did mother exercise? ○ Yes ○ No If yes, please explain: ______________________________
Was mother ill? ○ Yes ○ No If yes, please explain: ______________________________
Any ultrasounds? ○ Yes ○ No If yes, please explain: ______________________________

Please explain any noticable 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 weeks was your child born?

Where was your child born? – Who delivered your baby?

Please indicate 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 min.:

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 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 vaccine 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 TV, computer, tablet or phone?

How would you describe your child's diet? ○ Mostly whole, organic foods ○ Pretty average ○ High amount of processed foods

Acknowledgement & Consent

Parent/Guardian Signature: ______________________________ Date: ____________

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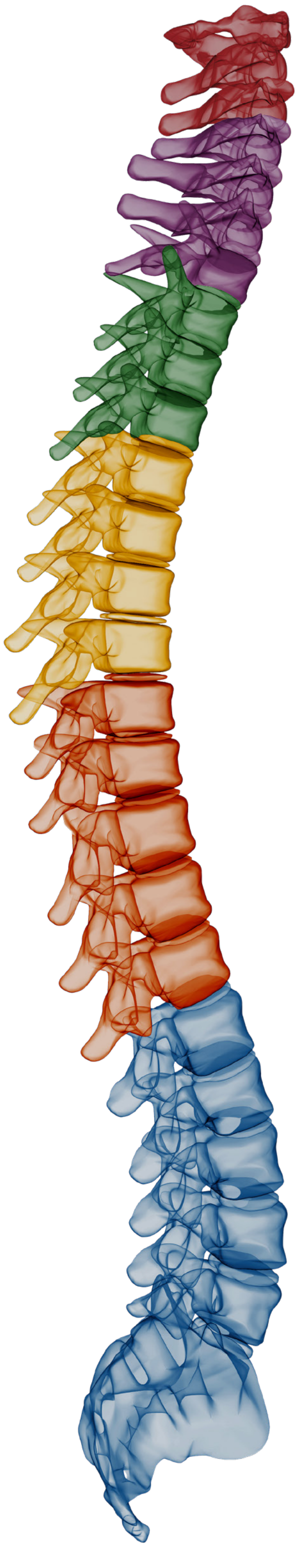
Patient Review of Systems

THE NERVOUS SYSTEM CONTROLS AND COORDINATES ALL ORGANS AND STRUCTURES OF THE HUMAN BODY

Please check the corresponding boxes for each symptom or condition you have experienced – including both past and present.



REGIONS	FUNCTIONS	SYMPTOMS (PAST / PRESENT)	SYMPTOMS (PAST / PRESENT)
Cervical	• Autonomic Nervous System • ENT System • Vision, Balance & Coordination • Speech • Immune System • Digestive System • Nerve Supply to Shoulders, Arms & Hands • Sympathetic Nucleus • Metabolism	☐ ☐ 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	• Upper G.I. • Respiratory System • Cardiac Function	☐ ☐ Reflux / GERD ☐ ☐ Chronic Colds & Cough ☐ ☐ Asthma	☐ ☐ Bronchitis & Pneumonia ☐ ☐ Functional Heart Conditions
Mid Thoracic	• Major Digestive Center • Detox & Immunity	☐ ☐ Gallbladder Pain / Issues ☐ ☐ Jaundice ☐ ☐ Fever	☐ ☐ Indigestion & Heartburn ☐ ☐ Stomach Pains & Ulcers ☐ ☐ Blood Sugar Problems
Lower Thoracic	• Stress Response • Filtration & Elimination • Gut & Digestion • Hormonal Control	☐ ☐ Behavior Issues ☐ ☐ Hyperactivity ☐ ☐ Chronic Fatigue ☐ ☐ Chronic Stress	☐ ☐ Allergies & Eczema ☐ ☐ Skin Conditions / Rash ☐ ☐ Kidney Problems ☐ ☐ Gas Pain & Bloating
Lumbar, Sacrum & Pelvis	• Lower G.I. (Absorption & Motility) • Gut-Immune System • Major Hormonal Control	☐ ☐ 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

Patient Name: ______________________________ Date: ____________