Pediatric Questionnaire

CONFIDENTIAL PATIENT INFORMATION

Child's Name_____ Parent/Guardian Name(s)_____

Birthdate_____/_____/_____ Age_____ Gender M / F Height:_____ft_____in Weight:_____lbs

Address_____ City_____ State_____ Zip_____

Parent 1 Cell_____ Parent 1 Email_____

Parent 2 Cell_____ Parent 2 Email_____

Primary Care Physician_____ How did you hear about us?_____

Is your child receiving care from any other health professionals? No / Yes - please name them and their specialty below:

_____

List any drugs/medications/vitamins/herbs/other that your child is taking:

_____

CURRENT HEALTH CONCERNS (IF NONE, SKIP TO HEALTH GOALS)

List your child's health concern(s) below:

_____

When did this first begin? _____ How did the problem start? Suddenly / Gradually / Post Injury

Has your child received care for this concern before? No / Yes - please explain:

_____

Is this condition: Getting Worse / Improving / Intermittent / Constant / Unsure

HEALTH GOALS FOR YOUR CHILD

What are your top three health goals for your child?

1 _____

2 _____

3 _____

What would you like to gain from chiropractic care?

Resolve Existing Condition / Wellness / Both

Has your child ever visited a chiropractor? No / Yes - Who?_____

What is their specialty? Pain Relief / Physical Therapy and Rehab / Nutritional / Subluxation-Based / Other_____

PREGNANCY AND FERTILITY HISTORY

Please tell us about your pregnancy with this child.

Any fertility issues? No / Yes - please explain: _____

Did mother smoke? No / Yes - how many per week? _____

Did mother drink? No / Yes - how many per week? _____

Did mother exercise? No / Yes - please explain: _____

Was mother ill? No / Yes - please explain: _____

Any ultrasounds? No / 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:

_____

_____

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LABOR AND DELIVERY HISTORY

At how many weeks was your child born? _____ The birth was: Vaginal / Scheduled Cesarean / Emergency Cesarean

Child was born at: Home / Birthing Center / Hospital / Other:_____ Doctor/OB Name_____

Please circle 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:_____lbs _____oz Child's birth height:_____in APGAR Score after 1 min:____/10 Score after 5 mins:____/10

GROWTH AND DEVELOPMENT HISTORY

Is/was your child breastfed? No / Yes - how long?_____ Did they ever use formula? No / Yes - what age? _____

Difficulty breastfeeding? No / Yes Tongue Tie Revision? No / Yes Lip Tie Revision? No / Yes

At what age did the child: Hold their head up _____ Sit alone_____ Crawl_____

Please list your child's hospitalization and surgical history:

_____

Please list any major injuries, accidents, falls and/or fractures your child has sustained in their lifetime:

_____

Have you chosen to vaccinate your child? No / Yes on Schedule / Yes on Delayed or Selective Schedule

Please list any vaccination reactions: _____

Has your child received any antibiotics? No / Yes - How many times and list reasons below:

_____

How would you describe your child's diet? Mostly whole organic food / Pretty average / High amount of processed food

How many bowel movements per day does your child have? _____

How many hours per day does your child typically spend watching a TV, computer, tablet or phone? _____

OTHER HISTORY (Check all that apply)

- ☐ ADD/ADHD
- ☐ Allergies
- ☐ Asthma
- ☐ Autism
- ☐ Bed Wetting
- ☐ Behavioral/Social/Emotional Issues
- ☐ Colic
- ☐ Constipation
- ☐ Diarrhea
- ☐ Frequent Crying Spells
- ☐ Frequent Ear Infections
- ☐ Frequent Illness (Fever/Cold/Sick)
- ☐ Growing Pains
- ☐ Headaches
- ☐ Motor or Speech Delays
- ☐ Night Terrors or Difficulty Sleeping
- ☐ OCD
- ☐ Reflux
- ☐ RSV
- ☐ Scoliosis
- ☐ Tonsillitis

Please list any other concerns you would like us to know about:

I hereby authorize the doctor to examine and treat my child as he/she deems appropriate through the use of chiropractic health care and I give authority for these procedures to be performed. It is understood and agreed that any necessary imaging is for examination only and will remain the property of this office. By signing below, I am acknowledging that I have read and understand the foregoing.

Printed Parent Name _____ Date_____

Parent Signature _____