PEDIATRIC HEALTH QUESTIONNAIRE

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Please take the time to fill out this questionnaire as completely as possible. This will assist us in performing a thorough assessment of your child's spinal health.

Child's Name _____ ***DOB*** _____

Parent's Name _____

Address _____

Phone Number_____ ***Email***_____ _____

What is the purpose of this office visit? Spinal check-up? ❒ or Other ❒
Pease specify your concerns_____
_____

Mom's Pregnancy
Did you have any problems during pregnancy? (Toxemia, Diabetes, water retention, high blood pressure, allergies, food intolerance, back pain, nausea, vomiting, heartburn, etc)
_____
_____

DELIVERY
Was your child full term? Yes❒ No❒ Number of weeks early_____ late_____
How long was your labour _____
Was any medication used? _____
Was your delivery: Vaginal ❒ Cesarean ❒ Forceps❒ Suction❒ Episiotomy❒
Did you experience any other complications?
_____

NEONATAL LIFE
Did the baby cry right away? Yes❒ No ❒ Apgar score (if known)_____
Were there any problems immediately after birth? (Jaundice, blood transfusion, etc)
_____
Birth weight_____ Present weight_____

INFANCY
Are there any particular activities that your child enjoys?_____
What position does your child sleep in? Side❒ Back ❒Front❒
What position does your child sit on the floor? Cross-legged ❒ "W" style❒Kneeling❒
Other _____
Has your child ever been hospitalized? No ❒ Yes ❒
Reason_____
Any prior x-rays? Date (approximate) _____ Age _____
Reason_____

PARENT/GUARDIAN CONSENT to treatment and/or radiographs*(for persons under age 18)*

I, _____ (parent/legal guardian)consent to chiropractic treatment, or x-rays (if necessary) of _____ (child's name)at Family Chiropractic Centre

_____ _____
Parent/Legal Guardian's signature Date