

PEDIATRIC PATIENT QUESTIONNAIRE

PATIENT INFORMATION

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

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Is it okay to contact you at work? Yes No

E-mail _____ Birthdate _____ Age _____

Have you or your child ever had chiropractic care before? Yes No

If yes, please tell us the doctor's name _____

Were you pleased with your care? Yes No

How did you find out about our office? _____

Is this appointment related to an auto accident? Yes No

If this appointment is related to an auto accident, please fill out then Auto Accident Questionnaire.

Is your child receiving care from other health professionals? Yes No

If yes, please name them and their specialty _____

Who is your family's primary care physician? _____

Please list any drugs or medications your child is taking _____

Please list any vitamins/herbs/homeopathics/other your child is taking _____

Please list any allergies your child has _____

CURRENT HEALTH

What health condition brings your child to our office? _____

When did the symptoms first begin? _____

How did the problem start? Suddenly Gradually Post-injury

Is this condition Getting worse Improving Intermittent Constant Not Sure

What makes the problem better? _____

What makes the problem worse? _____

Has your child ever had a similar condition? Yes No

Please explain _____

Has your child been treated for this problem before? Yes No

Please explain _____

Does your child eat well? Yes No Does your child have regular bowel/bladder movements? Yes No

Has your child ever been checked for vertebral subluxations? Yes No Don't Know