

PEDIATRIC QUESTIONNAIRE

Name: (Last, First MI) _____

Today's Date: _____



PEDIATRIC REVIEW OF SYSTEMS

Pediatric:

- ADHD
- Allergies/Asthma
- Autism
- Back/Neck Pain
- Bed Wetting
- Behavioral issues
- Chronic Earaches
- Colic
- Constipation
- Growing Pains
- Nightmares
- Reflux
- None in this Category

Childhood Diseases:

- Chicken Pox: Age _____
- Measles: Age _____
- Meningitis: Age _____
- Mumps: Age _____
- Rubella: Age _____
- Tuberculosis: Age _____
- Whooping Cough: Age _____
- Other: _____ Age _____
- None in this Category

Has your child been vaccinated?

- No Yes
(Any Adverse Reactions? – Describe:) _____



INFANTS AND NEWBORNS

Prenatal History:

Location of Birth: Home Birthing Center Hospital

Birth Weight: _____ Birth Length: _____ Full Term? No Yes (Describe) _____

Complications during pregnancy? No Yes (Describe) _____

Medications during pregnancy or delivery? No Yes (List) _____

Cigarette / Alcohol / Drugs during pregnancy? No Yes (List) _____

Birth Interventions? No Yes Forceps Vacuum Caesarian Other: _____

Complications during delivery? No Yes (Describe) _____

Feeding History:

Breast fed? No Yes (How Long?) _____ Formula fed? No Yes (How Long?) _____ (Type?) _____

Introduced to cereal at _____ months old. Solids at _____ months old. Cow's milk at _____ months old.

Food / Juice allergies or intolerances? No Yes (Describe) _____

Developmental History:

Sleep (Hours per Night?) _____ Problems Sleeping? (Describe) _____

CONSENT FOR TREATMENT OF A MINOR

I hereby authorize: _____ (Doctor's Name) and whomever he or she may designate as assistants to administer examinations and chiropractic care as deemed necessary to: _____ (Minor Patient's Name)

Printed Name of Parent or Guardian

Signature of Parent or Guardian

Date

Witness

Date

Patient No: _____