

# Pediatric Patient Questionnaire

## CONFIDENTIAL PATIENT INFORMATION

Child's Name:	Parent/Guardian Name(s):		
Street Address:	City:	State:	Zip:
Cell Phone: - -	Home Phone: - -	Work Phone: - -	
Email:	Child's SS #: - -	Birthdate: / /	Age:
How did you hear about us?	Height: ft.	in.	Weight: lbs.
Who is your primary care physician?			
Is your child receiving care from any other health professionals? <input type="radio"/> Yes <input type="radio"/> No - If yes, please name them and their specialty:			
Please list any drugs/medications/vitamins/herbs/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 before?  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:	What would you like to gain from chiropractic care?
1. _____	<input type="radio"/> Resolve existing condition
2. _____	<input type="radio"/> Overall wellness
3. _____	<input type="radio"/> Both
Have you ever visited a chiropractor? <input type="radio"/> Yes <input type="radio"/> No If yes, what is their name?	
What is their specialty? <input type="radio"/> Pain Relief <input type="radio"/> Physical Therapy & Rehab <input type="radio"/> Nutritional <input type="radio"/> Subluxation-based <input type="radio"/> 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 many per week? \_\_\_\_\_

Did mother drink?  Yes  No If yes, how many per week? \_\_\_\_\_

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 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: \_\_\_\_\_

## LABOR & DELIVERY HISTORY

Child's birth was:  Natural vaginal birth  Scheduled C-section  Emergency C-section At how many week's was your child born?

Child's birth was:  At home  At a birthing center  At a hospital  Other: \_\_\_\_\_ Doctor/Obstetrician's Name: \_\_\_\_\_

Please check 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 at birth: \_\_\_\_\_ APGAR score after 5 minutes: \_\_\_\_\_

## 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 ever 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 vaccination 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 a 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

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

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