Pediatric Patient Questionnaire

CONFIDENTIAL PATIENT INFORMATION

Child's Name: Parent's Names: Date: / /

DOB: / / Age: Sex: M F

Street Address: City: State: Zip:

# of Children: Names/Ages of Children:

Height: ft. in. Weight: lbs

Email: Cell Phone: - -

How did you hear about us?

Health insurance provider: ID number:

It is likely that your health insurance will not cover care for your child. We will discuss all costs prior to care.

HEALTH GOALS FOR YOUR CHILD

What would your family like to gain from care in our office?

What are your top 3 health goals for your child?

CURRENT HEALTH CONDITIONS

What health condition(s) brings your family into our office?

Has your child received care for this problem before? Yes No

When did the condition(s) first begin? Is this affecting your child's sleep? Yes No

How did the problem start?

On a scale of 0-10, how much does their problem bother your family?

What makes the problem better?

What makes the problem worse?

Has your child been to a chiropractor before? Yes No If yes, who?

PREGNANCY HISTORY

Any fertility issues? Yes No If yes, please explain:

How many ultrasounds?

Any illnesses for mother? Yes No If yes, please explain:

Did the mother have any falls or physical injuries?

Please explain any notable emotional stress during pregnancy:

Pediatric Patient Questionnaire Contd.

LABOR & DELIVERY HISTORY

Child's birth was: Vaginal Scheduled C-Section Emergency C-Section

At how many weeks was your child born? Were you induced? Yes No

Child was born at: Home Sanford St. Alexius Other______________ OB/GYN's name:

Child's position during delivery was: Head down Occiput posterior (face up) Breech Transverse

Birth Weight: lbs oz Birth Height: in

How long was the labor process? How long were you pushing?

Were vacuum or forceps used? Yes No

Was there any bruising or evidence of trauma at birth?

Was the child in the NICU at all? Yes No If yes, please explain:

GROWTH AND DEVELOPMENT HISTORY

Is/was your child breastfed? Yes No If yes, how long? Difficulty breastfeeding? Yes No
Is/was your child fed formula? Yes No If yes, how long?

Did/does your child suffer from colic, reflux, or constipation? Yes No
If yes, please explain:
At what age did the child: Sit alone_______ Crawl_______ Walk_______ Begin cow's milk_______ Begin solid foods_______
Does your child frequently arch their neck/back, feel stiff, or bang their head? Yes No
If yes, please explain:

Have you chosen to vaccinate your child? No Yes, fully Yes, on a selective schedule
Do you have any concerns about your child's vaccinations?

Please list any major injuries, accidents, falls, or fractures:

Please list any hospitalizations or surgeries:

Please list any food intolerance or allergies:

Has your child received any antibiotics? Yes No If yes, how many times and for what?

Is your child taking any medications? Yes No

Night terrors, bedwetting, or difficulty sleeping? Yes No If yes, please explain:
Behavioral, social, or emotional issues? Yes No If yes, please explain:
Are there any other concerns you have for your child?

ACKNOWLEDGMENT AND CONSENT

Parent signature:_______________________________ Date_______________

Patient Review of Systems

THE NERVOUS SYSTEM CONTROLS AND COORDINATES ALL CELLS IN THE BODY

Please check the corresponding boxes for each symptom or condition you have experienced - including both past and present.

REGIONS	PAST	PRESENT	SYMPTOMS	PAST	PRESENT	SYMPTOMS
Cervical	☐	☐	Colic & Excessive Crying	☐	☐	Epilepsy & Seizures
	☐	☐	Ear & Sinus Infections	☐	☐	Sensory & Spectrum
	☐	☐	Allergies & Congestion	☐	☐	ADD/ADHD
	☐	☐	Migraines	☐	☐	Focus & Memory Issues
	☐	☐	Headaches	☐	☐	Anxiety & Stress
	☐	☐	Vertigo & Dizziness	☐	☐	Balance & Coordination
	☐	☐	Sore Throat	☐	☐	Speech Issues
	☐	☐	Swollen Tonsils	☐	☐	TMJ / Jaw Pain
	☐	☐	Vision & Hearing Issues	☐	☐	Stiff Neck & Shoulders
	☐	☐	Low Energy & Fatigue	☐	☐	Depression
	☐	☐	Difficulty Sleeping	☐	☐	High Blood Pressure
	☐	☐	Pain, Numbness & Tingling in Arms to Hands	☐	☐	Poor Metabolism & Weight Control
Upper Thoracic	☐	☐	Reflux / GERD	☐	☐	Bronchitis & Pneumonia
	☐	☐	Chronic Colds & Cough	☐	☐	Heart Condition
	☐	☐	Asthma			
Mid Thoracic	☐	☐	Gallbladder Issues	☐	☐	Indigestion & Heartburn
	☐	☐	Jaundice	☐	☐	Stomach Pains & Ulcers
	☐	☐	Fever	☐	☐	Blood Sugar Problems
Lower Thoracic	☐	☐	Behavior Issues	☐	☐	Allergies & Eczema
	☐	☐	Hyperactivity	☐	☐	Skin Conditions / Rash
	☐	☐	Chronic Fatigue	☐	☐	Kidney Problems
	☐	☐	Chronic Stress	☐	☐	Gas Pain & Bloating
Lumbar, Sacrum, & Pelvis	☐	☐	Constipation	☐	☐	Sciatica & Radiating Pain
	☐	☐	Crohn's, Colitis & IBS	☐	☐	Lumbopelvic / SI Joint Pain
	☐	☐	Diarrhea	☐	☐	Hamstring Tightness
	☐	☐	Bed-wetting	☐	☐	Disc Degeneration
	☐	☐	Bladder & Urination Issues	☐	☐	Leg Weakness & Cramps
	☐	☐	Cramps & Menstrual Issues	☐	☐	Poor Circulation & Cold Feet
	☐	☐	Cysts & Endometriosis	☐	☐	Knee , Ankle & Foot Pain
	☐	☐	Infertility	☐	☐	Weak Ankles & Arches
	☐	☐	Impotency	☐	☐	Lower Back Pain
	☐	☐	Hemorrhoids	☐	☐	Gluten & Casein Intolerance

Patient Name: ______________________________ Date: / /