EPIC Kiddos Questionnaire

HEALTH GOALS FOR YOUR CHILD

Your top three Health Goals for your child:	What would you like to gain from care?
1	○ Resolve existing condition
2	○ Overall Wellness
3	○ Both

Have you ever visited a chiropractor? ○ Yes ○ No If yes, name and how long ago?

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 weeks was your child born?

Child's birth was: ○ At home ○ At a birthing center ○ At a hospital ○ Other: Doctor/OBGYN's Name:

Please check any applicable interventions or complications:
○ Breech ○ Induction ○ Pain meds ○ Epidural ○ Vacuum extraction ○ Forceps ○ Other_____

Please describe any other concerns or notable remarks about your child's labor and/or delivery:

Child's birth weight: Child's birth height:

GROWTH & DEVELOPMENT HISTORY

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

Did they 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

At what age did the child: Respond to sound: _____ Follow an object: _____ Hold their head up: _____ Vocalize: _____ Teeth: _____
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, but on a delayed or selective schedule ○ Yes, on schedule
- if yes, please list any vaccination reactions (if any):

Has your child received any antibiotics? ○ Yes ○ No
- if yes, how many times and list reason(s):

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 amounts of processed foods