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? ◯ Yes ◯ 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:

1. _____
2. _____
3. _____

What would you like to gain from chiropractic care?

◯ Resolve existing condition
◯ Overall wellness
◯ Both

Have you ever visited a chiropractor? ◯ Yes ◯ No If yes, what is their name?

What is their specialty? ◯ Pain Relief ◯ Physical Therapy & Rehab ◯ Nutritional ◯ Subluxation-based ◯ 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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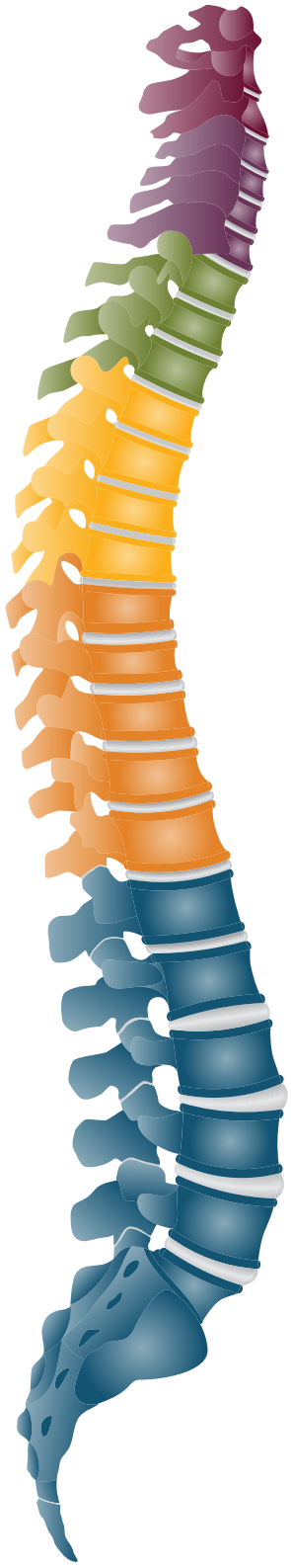
Patient Review of Systems

THE NERVOUS SYSTEM CONTROLS AND COORDINATES ALL ORGANS AND STRUCTURES OF THE HUMAN BODY

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



REGIONS	FUNCTIONS	SYMPTOMS			
		PAST	PRESENT	PAST	PRESENT
Cervical	• Autonomic Nervous System • ENT System • Vision, Balance & Coordination • Speech • Immune System • Digestive System • Nerve Supply to Shoulders, Arms & Hands • Sympathetic Nucleus • Metabolism	☐	☐	Colic & Excessive Crying	Epilepsy & Seizures
		☐	☐	Ear & Sinus Infections	Sensory & Spectrum
		☐	☐	Allergies & Congestion	ADD / ADHD
		☐	☐	Immune Deficiency	Focus & Memory Issues
		☐	☐	Headaches & Migraines	Anxiety & Stress
		☐	☐	Vertigo & Dizziness	Balance & Coordination
		☐	☐	Sore Throat & Strep	Speech Issues
		☐	☐	Swollen Tonsils & Adenoids	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	• Upper G.I. • Respiratory System • Cardiac Function	☐	☐	Reflux / GERD	Bronchitis & Pneumonia
		☐	☐	Chronic Colds & Cough	Functional Heart Conditions
		☐		Asthma	
Mid Thoracic	• Major Digestive Center • Detox & Immunity	☐	☐	Gallbladder Pain / Issues	Indigestion & Heartburn
		☐	☐	Jaundice	Stomach Pains & Ulcers
		☐	☐	Fever	Blood Sugar Problems
Lower Thoracic	• Stress Response • Filtration & Elimination • Gut & Digestion • Hormonal Control	☐	☐	Behavior Issues	Allergies & Eczema
		☐	☐	Hyperactivity	Skin Conditions / Rash
		☐	☐	Chronic Fatigue	Kidney Problems
		☐	☐	Chronic Stress	Gas Pain & Bloating
Lumbar, Sacrum & Pelvis	• Lower G.I. (Absorption & Motility) • Gut-Immune System • Major Hormonal Control	☐	☐	Constipation	Sciatica & Radiating Pain
		☐	☐	Chrohn'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: ___/___/___