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 pregnacy:

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.

Basic Nutrition Questionnaire

Has your child been diagnosed as a diabetic?
YES/NO

Has your child been diagnosed as Pre-diabetic or Metabolic Syndrome? YES/NO

How many days a week does your child skip a meal? (3/meals/day) ________

How many "fast food", "refined food", or "pre-prepared" meals does your child eat per week?

(0) (1-3) (4-6) (7+)

How many serving of fruit does your child eat per day?

(0-1) (2-3) (4-5)

How many servings of vegetables does your child eat per day?

(0-1) (2-3) (4-5)

Does your child regularly drink 1 or more per day of the following: (circle all that apply)

Soda Coffee Juice Milk

How many servings of refined sugar does your child eat per day? (candy, cookies, cake, etc.)

(0-1) (2-3) (4-5)

Please list all nutritional supplements/vitamins your child takes regularly:

____

____

____

SYMPTOMS

PAST	PRESENT	Symptom	PAST	PRESENT	Symptom
☐	☐	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
☐	☐	Reflux / GERD	☐	☐	Bronchitis & Pneumonia
☐	☐	Chronic Colds & Cough	☐	☐	Functional Heart Conditions
☐	☐	Asthma			
☐	☐	Gallbladder Pain / Issues	☐	☐	Indigestion & Heartburn
☐	☐	Jaundice	☐	☐	Stomach Pains & Ulcers
☐	☐	Fever	☐	☐	Blood Sugar Problems
☐	☐	Behavior Issues	☐	☐	Allergies & Eczema
☐	☐	Hyperactivity	☐	☐	Skin Conditions / Rash
☐	☐	Chronic Fatigue	☐	☐	Kidney Problems
☐	☐	Chronic Stress	☐	☐	Gas Pain & Bloating
☐	☐	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: ___/___/_____

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