Pediatric Patient Questionnaire

Child's Name _____
Parent(s)/Guardian(s) Name(s) _____
Address _____
City/State/Zip _____
Phone #s _____(home) _____(cell) _____(work)

Is it okay to contact you at work? ○ Yes ○ No
E-mail address _____
Child's Social Security #_____ Birthdate_____ Age _____

Have you or your child ever had chiropractic care before? ○Yes ○No
If yes, please tell us the doctor's name _____

Were you pleased with your care? ○Yes ○No
How did you find out about our office? _____

Is this appointment related to an auto accident ○Yes ○No
If this injury is related to an auto accident, please fill out the Auto Accident Form.

Is your child receiving care from other health professionals? ○Yes ○No
If yes, please name them and their specialty _____
Who is your family's primary care physician? _____
Please list any drugs or medications your child is taking _____
_____
Please list any vitamins/herbs/homeopathics/other your child is taking _____
_____
Please list any allergies your child has _____
_____

Current Health

What health condition brings your child to our office? _____
_____
When did the symptoms first begin? _____

How did the problem start? ○suddenly ○gradually ○post-injury

Is this condition ○getting worse ○improving ○intermittent ○constant ○not sure
What makes the problem better? _____
What makes the problem worse? _____

Has your child ever had a similar condition? ○Yes ○No
Please explain _____

Has your child been treated for this problem before? ○Yes ○No
Please explain _____

Does your child eat well? ○Yes ○No

Does your child have regular bowel/bladder movements? ○Yes ○No

Has your child ever been checked for VERTEBRAL SUBLUXATIONS? ○Yes ○No ○Don't Know

Health History

Birth History

Child's birth was ○at home ○at a birthing center ○at a hospital

My obstetrician/midwife/family physician was _____

Child's birth was ○natural vaginal (no medications/interventions)

○vaginal with interventions

○induction ○pain medication ○epidural

○episiotomy ○vacuum extraction ○forceps ○other _____

○C-section ○scheduled ○emergency

Please list reasons for any interventions/complications _____

_____

Child's birth weight & height_____ Current weight & height _____

APGAR score at birth_____ APGAR score after 5 minutes _____

Growth and Development

Was your child alert and responsive within 12 hours of delivery? ○Yes ○No

If no, please explain _____

At what age did the child:

Respond to sound_____ Follow an object_____ Hold head up _____

Vocalize_____ Sit alone_____ Teethe _____

Crawl_____ Walk _____

Patient Hospitalization/Surgical History (Please List below all surgeries and hospitalizations, including year) _____

Please list any major injuries/accidents/falls/fractures your child has sustained in his/her lifetime, including year: _____

Chemical Stressors

Is/was your child breastfed? ○Yes ○No If yes, How long? _____

Formula introduced at age_____ What type? _____

Introduction of cow's milk at age_____ Began solid foods at age _____

Please list any food/juice intolerance _____

Did mother smoke during pregnancy? ○Yes ○No

Did mother drink alcohol during pregnancy? ○Yes ○No

Any illness of mother during pregnancy? ○Yes ○No

If yes, Please explain, including treatment/medication/supplements _____

_____

List any drugs/medications (including over the counter) taken during pregnancy _____

_____

List any supplements taken during pregnancy _____

_____

Any exposures to ultrasound? ○Yes ○No If so, how many and what was medical reason? ____

_____

Any pets at home? ○Yes ○No Any smokers at home? ○Yes ○No

Has child received any vaccinations? ○Yes ○No If yes, which ones and list any reactions ____

_____

Has child received any antibiotics? ○Yes ○No If yes, how many times and list reason _____

_____

Psychosocial Stressors

Any difficulty with breastfeeding? ○Yes ○No If yes, please explain _____

_____

Any difficulty with bonding? ○Yes ○No If yes, please explain _____

_____

Any behavioral problems? ○Yes ○No If yes, please explain _____

_____

Any night terrors/sleepwalking/difficulty sleeping? ○Yes ○No If yes, please explain _____

_____

Age child began daycare_____ Average number of hours of TV per week _____

Does your child seem normal for their age? ○Yes ○No If no, please explain _____

_____

Family History Review (check those involving immediate family and add identification: M=mother F=father S=siblings G=grandparents)

[ ]cancer (type) [ ]depression [ ]diabetes [ ]back problems
[ ]heart disease [ ]liver disease [ ]high blood pressure
[ ]high cholesterol [ ]lung problems [ ]scoliosis [ ]neck problems
[ ]osteoporosis [ ]seizures [ ]osteoarthritis [ ]rheumatoid arthritis
[ ]Other _____

What do you know about Chiropractic?

Do you know what a subluxation is? ○Yes ○No

Do any of your friends or relatives see a chiropractor? ○Yes ○No

If yes, do they use chiropractic for ○health maintenance/optimization ○health problems ○both

Are you seeking chiropractic for ○health maintenance/optimization ○health problems ○both

What would you like to gain from chiropractic care? _____

_____

Are there other health concerns or anything else you'd like us to know about your child? _____

_____