

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? <input type="radio"/> Yes <input type="radio"/> 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:	What would you like to gain from chiropractic care?
1. _____	<input type="radio"/> Resolve existing condition
2. _____	<input type="radio"/> Overall wellness
3. _____	<input type="radio"/> Both
Have you ever visited a chiropractor? <input type="radio"/> Yes <input type="radio"/> No If yes, what is their name? _____	
What is their specialty? <input type="radio"/> Pain Relief <input type="radio"/> Physical Therapy & Rehab <input type="radio"/> Nutritional <input type="radio"/> Subluxation-based <input type="radio"/> 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	<input type="checkbox"/> <input type="checkbox"/>	Colic & Excessive Crying	<input type="checkbox"/> <input type="checkbox"/>	Epilepsy & Seizures
	• ENT System	<input type="checkbox"/> <input type="checkbox"/>	Ear & Sinus Infections	<input type="checkbox"/> <input type="checkbox"/>	Sensory & Spectrum
	• Vision, Balance & Coordination	<input type="checkbox"/> <input type="checkbox"/>	Allergies & Congestion	<input type="checkbox"/> <input type="checkbox"/>	ADD / ADHD
	• Speech	<input type="checkbox"/> <input type="checkbox"/>	Immune Deficiency	<input type="checkbox"/> <input type="checkbox"/>	Focus & Memory Issues
	• Immune System	<input type="checkbox"/> <input type="checkbox"/>	Headaches & Migraines	<input type="checkbox"/> <input type="checkbox"/>	Anxiety & Stress
	• Digestive System	<input type="checkbox"/> <input type="checkbox"/>	Vertigo & Dizziness	<input type="checkbox"/> <input type="checkbox"/>	Balance & Coordination
	• Nerve Supply to Shoulders, Arms & Hands	<input type="checkbox"/> <input type="checkbox"/>	Sore Throat & Strep	<input type="checkbox"/> <input type="checkbox"/>	Speech Issues
	• Sympathetic Nucleus	<input type="checkbox"/> <input type="checkbox"/>	Swollen Tonsils & Adenoids	<input type="checkbox"/> <input type="checkbox"/>	TMJ / Jaw Pain
	• Metabolism	<input type="checkbox"/> <input type="checkbox"/>	Vision & Hearing Issues	<input type="checkbox"/> <input type="checkbox"/>	Stiff Neck & Shoulders
			<input type="checkbox"/> <input type="checkbox"/>	Low Energy & Fatigue	<input type="checkbox"/> <input type="checkbox"/>
		<input type="checkbox"/> <input type="checkbox"/>	Difficulty Sleeping	<input type="checkbox"/> <input type="checkbox"/>	High Blood Pressure
		<input type="checkbox"/> <input type="checkbox"/>	Pain, Numbness & Tingling in Arms to Hands	<input type="checkbox"/> <input type="checkbox"/>	Poor Metabolism & Weight Control
Upper Thoracic	• Upper G.I.	<input type="checkbox"/> <input type="checkbox"/>	Reflux / GERD	<input type="checkbox"/> <input type="checkbox"/>	Bronchitis & Pneumonia
	• Respiratory System	<input type="checkbox"/> <input type="checkbox"/>	Chronic Colds & Cough	<input type="checkbox"/> <input type="checkbox"/>	Functional Heart Conditions
	• Cardiac Function	<input type="checkbox"/> <input type="checkbox"/>	Asthma		
Mid Thoracic	• Major Digestive Center	<input type="checkbox"/> <input type="checkbox"/>	Gallbladder Pain / Issues	<input type="checkbox"/> <input type="checkbox"/>	Indigestion & Heartburn
	• Detox & Immunity	<input type="checkbox"/> <input type="checkbox"/>	Jaundice	<input type="checkbox"/> <input type="checkbox"/>	Stomach Pains & Ulcers
		<input type="checkbox"/> <input type="checkbox"/>	Fever	<input type="checkbox"/> <input type="checkbox"/>	Blood Sugar Problems
Lower Thoracic	• Stress Response	<input type="checkbox"/> <input type="checkbox"/>	Behavior Issues	<input type="checkbox"/> <input type="checkbox"/>	Allergies & Eczema
	• Filtration & Elimination	<input type="checkbox"/> <input type="checkbox"/>	Hyperactivity	<input type="checkbox"/> <input type="checkbox"/>	Skin Conditions / Rash
	• Gut & Digestion	<input type="checkbox"/> <input type="checkbox"/>	Chronic Fatigue	<input type="checkbox"/> <input type="checkbox"/>	Kidney Problems
	• Hormonal Control	<input type="checkbox"/> <input type="checkbox"/>	Chronic Stress	<input type="checkbox"/> <input type="checkbox"/>	Gas Pain & Bloating
Lumbar, Sacrum & Pelvis	• Lower G.I. (Absorption & Motility)	<input type="checkbox"/> <input type="checkbox"/>	Constipation	<input type="checkbox"/> <input type="checkbox"/>	Sciatica & Radiating Pain
		<input type="checkbox"/> <input type="checkbox"/>	Chrohn's, Colitis & IBS	<input type="checkbox"/> <input type="checkbox"/>	Lumbopelvic / SI Joint Pain
	• Gut-Immune System	<input type="checkbox"/> <input type="checkbox"/>	Diarrhea	<input type="checkbox"/> <input type="checkbox"/>	Hamstring Tightness
	• Major Hormonal Control	<input type="checkbox"/> <input type="checkbox"/>	Bed-wetting	<input type="checkbox"/> <input type="checkbox"/>	Disc Degeneration
		<input type="checkbox"/> <input type="checkbox"/>	Bladder & Urination Issues	<input type="checkbox"/> <input type="checkbox"/>	Leg Weakness & Cramps
		<input type="checkbox"/> <input type="checkbox"/>	Cramps & Menstrual Issues	<input type="checkbox"/> <input type="checkbox"/>	Poor Circulation & Cold Feet
		<input type="checkbox"/> <input type="checkbox"/>	Cysts & Endometriosis	<input type="checkbox"/> <input type="checkbox"/>	Knee, Ankle & Foot Pain
		<input type="checkbox"/> <input type="checkbox"/>	Infertility	<input type="checkbox"/> <input type="checkbox"/>	Weak Ankles & Arches
		<input type="checkbox"/> <input type="checkbox"/>	Impotency	<input type="checkbox"/> <input type="checkbox"/>	Lower Back Pain
		<input type="checkbox"/> <input type="checkbox"/>	Hemorrhoids	<input type="checkbox"/> <input type="checkbox"/>	Gluten & Casein Intolerance

Patient Name: _____

Date: ____ / ____ / ____