Pediatric Patient Questionnaire

Confidential Patient Information

Child's Name:	Parent/Guardian Name(s):		
Street Address:	City, State, Postal Code:		
Cell Phone:	Other Phone:	Child's Sex:	
Email:	Child's SSN:	Birthdate:	Age:
How did you hear about us?		Height:	Weight:

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 or 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? ○ 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?

○ Resolve existing condition
○ Overall wellness
○ Both

Has your child ever visited a chiropractor? ○ Yes ○ No – If yes, what is their name:

– What is their specialty: ○ Pain Relief ○ Physical Therapy & Rehab ○ Nutrition ○ 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 often? _____
Did mother drink? ○ Yes ○ No If yes, how often? _____
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 noticable 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?

Where was your child born? – Who delivered your baby?

Please indicate 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: Child's birth height: APGAR score at birth: APGAR score after 5 min.:

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 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 vaccine 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 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

Parent/Guardian Signature: _____ Date: _____

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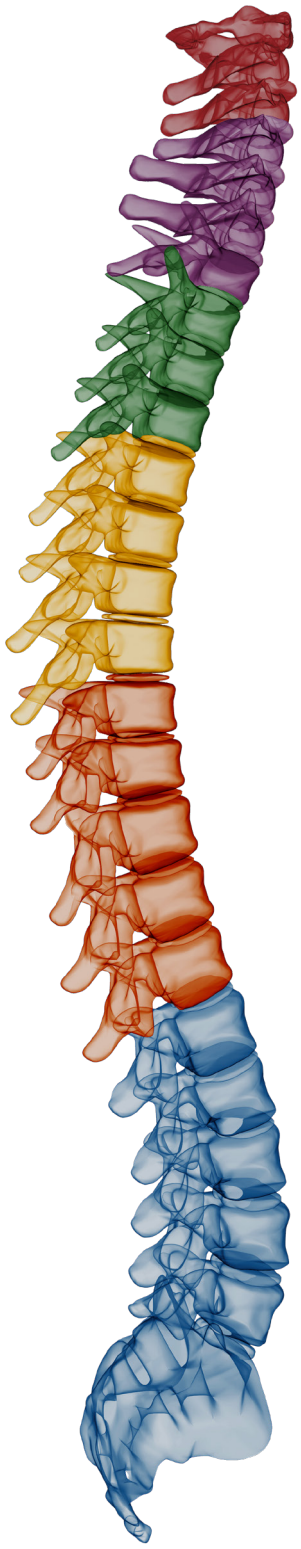
Patient Review of Systems

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.



Cervical

Functions

- Autonomic Nervous System
- ENT System
- Vision, Balance & Coordination
- Speech
- Immune System
- Digestive System
- Nerve Supply to Shoulders, Arms & Hands
- Sympathetic Nucleus
- Metabolism

Symptoms

PAST	PRESENT		PAST	PRESENT	
☐	☐	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

Functions

- Upper G.I.
- Respiratory System
- Cardiac Function

Symptoms

☐	☐	Reflux / GERD	☐	☐	Bronchitis & Pneumonia
☐	☐	Chronic Colds & Cough	☐	☐	Functional Heart Conditions
☐	☐	Asthma			

Mid Thoracic

Functions

- Major Digestive Center
- Detox & Immunity

Symptoms

☐	☐	Gallbladder Pain / Issues	☐	☐	Indigestion & Heartburn
☐	☐	Jaundice	☐	☐	Stomach Pains & Ulcers
☐	☐	Fever	☐	☐	Blood Sugar Problems

Lower Thoracic

Functions

- Stress Response
- Filtration & Elimination
- Gut & Digestion
- Hormonal Control

Symptoms

☐	☐	Behavior Issues	☐	☐	Allergies & Eczema
☐	☐	Hyperactivity	☐	☐	Skin Conditions / Rash
☐	☐	Chronic Fatigue	☐	☐	Kidney Problems
☐	☐	Chronic Stress	☐	☐	Gas Pain & Bloating

Lumbar, Sacrum & Pelvis

Functions

- Lower G.I. (Absorption & Motility)
- Gut-Immune System
- Major Hormonal Control

Symptoms

☐	☐	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: _____