

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? <input type="radio"/> Yes <input type="radio"/> 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? _____ What would you like to gain?

1. _____ Resolve existing condition

2. _____ Overall wellness

3. _____ 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 noticeable 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: _____

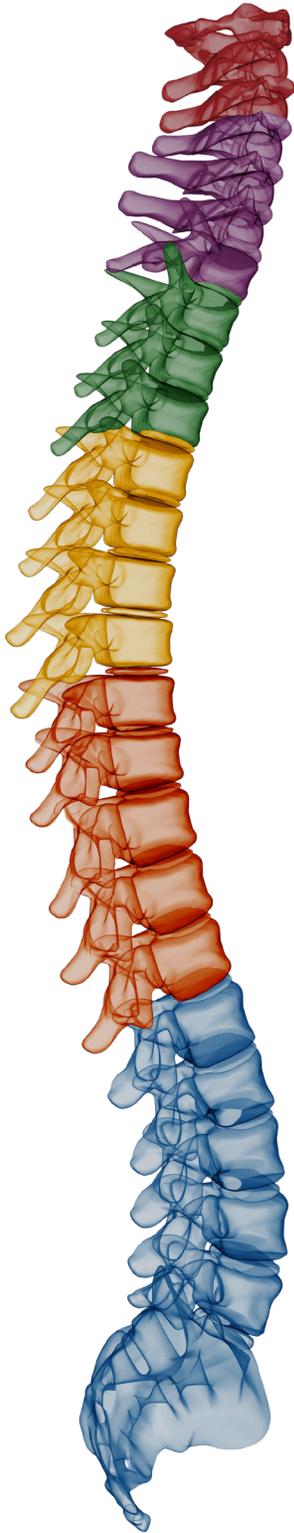
Date: _____

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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.



REGIONS	FUNCTIONS	SYMPTOMS			
		PAST PRESENT	PAST PRESENT		
Cervical	• Autonomic Nervous System	<input type="checkbox"/>	Colic & Excessive Crying	<input type="checkbox"/>	Epilepsy & Seizures
	• ENT System	<input type="checkbox"/>	Ear & Sinus Infections	<input type="checkbox"/>	Sensory & Spectrum
	• Vision, Balance & Coordination	<input type="checkbox"/>	Allergies & Congestion	<input type="checkbox"/>	ADD / ADHD
	• Speech	<input type="checkbox"/>	Immune Deficiency	<input type="checkbox"/>	Focus & Memory Issues
	• Immune System	<input type="checkbox"/>	Headaches & Migraines	<input type="checkbox"/>	Anxiety & Stress
	• Digestive System	<input type="checkbox"/>	Vertigo & Dizziness	<input type="checkbox"/>	Balance & Coordination
	• Nerve Supply to Shoulders, Arms & Hands	<input type="checkbox"/>	Sore Throat & Strep	<input type="checkbox"/>	Speech Issues
	• Sympathetic Nucleus	<input type="checkbox"/>	Swollen Tonsils & Adenoids	<input type="checkbox"/>	TMJ / Jaw Pain
	• Metabolism	<input type="checkbox"/>	Vision & Hearing Issues	<input type="checkbox"/>	Stiff Neck & Shoulders
		<input type="checkbox"/>	Low Energy & Fatigue	<input type="checkbox"/>	Depression
		<input type="checkbox"/>	Difficulty Sleeping	<input type="checkbox"/>	High Blood Pressure
		<input type="checkbox"/>	Pain, Numbness & Tingling in Arms to Hands	<input type="checkbox"/>	Poor Metabolism & Weight Control
	Upper Thoracic	• Upper G.I.	<input type="checkbox"/>	Reflux / GERD	<input type="checkbox"/>
• Respiratory System		<input type="checkbox"/>	Chronic Colds & Cough	<input type="checkbox"/>	Functional Heart Conditions
• Cardiac Function		<input type="checkbox"/>	Asthma		
Mid Thoracic	• Major Digestive Center	<input type="checkbox"/>	Gallbladder Pain / Issues	<input type="checkbox"/>	Indigestion & Heartburn
	• Detox & Immunity	<input type="checkbox"/>	Jaundice	<input type="checkbox"/>	Stomach Pains & Ulcers
		<input type="checkbox"/>	Fever	<input type="checkbox"/>	Blood Sugar Problems
Lower Thoracic	• Stress Response	<input type="checkbox"/>	Behavior Issues	<input type="checkbox"/>	Allergies & Eczema
	• Filtration & Elimination	<input type="checkbox"/>	Hyperactivity	<input type="checkbox"/>	Skin Conditions / Rash
	• Gut & Digestion	<input type="checkbox"/>	Chronic Fatigue	<input type="checkbox"/>	Kidney Problems
	• Hormonal Control	<input type="checkbox"/>	Chronic Stress	<input type="checkbox"/>	Gas Pain & Bloating
Lumbar, Sacrum & Pelvis	• Lower G.I. (Absorption & Motility)	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	Sciatica & Radiating Pain
	• Gut-Immune System	<input type="checkbox"/>	Chrohn's, Colitis & IBS	<input type="checkbox"/>	Lumbopelvic / SI Joint Pain
	• Major Hormonal Control	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	Hamstring Tightness
		<input type="checkbox"/>	Bed-wetting	<input type="checkbox"/>	Disc Degeneration
		<input type="checkbox"/>	Bladder & Urination Issues	<input type="checkbox"/>	Leg Weakness & Cramps
		<input type="checkbox"/>	Cramps & Menstrual Issues	<input type="checkbox"/>	Poor Circulation & Cold Feet
		<input type="checkbox"/>	Cysts & Endometriosis	<input type="checkbox"/>	Knee, Ankle & Foot Pain
		<input type="checkbox"/>	Infertility	<input type="checkbox"/>	Weak Ankles & Arches
		<input type="checkbox"/>	Impotency	<input type="checkbox"/>	Lower Back Pain
		<input type="checkbox"/>	Hemorrhoids	<input type="checkbox"/>	Gluten & Casein Intolerance

Patient Name: _____ Date: _____