Pediatric Chiropractic Health Questionnaire

Welcome to our Office!
Please answer the following questions:

Child's Name_____ Mother's Name_____
Last First Mi Last First Mi
Date of Birth_____ Age_____ Father's Name_____
Last First Mi
Address_____ City_____ State_____ Zip_____
Home Phone_____ Cell Number_____ Work Phone_____
SSN_____ Sex M or F Birth Weight _____Current Weight_____
Email_____@_____ Who referred you to our office?_____
Type of Birth: Normal/Vaginal_____ Forceps_____ Breech_____
Home_____ Hospital_____ Cesarean_____
Problem during pregnancy? _____
_____
Problem with labor/deliver? _____
_____
APGAR Scores:_____ _____ Present at Birth? Jaundice (yellow)_____Cyanosis (blue)_____
Congenital Anomalies/Defects: _____
Infant Feeding: Breast_____ Bottle_____ Formula_____
Quality of Sleep: Good_____ Fair_____ Poor_____
Immunization History_____
Any childhood diseases?_____
Purpose of Last Visit to MD_____Date_____
Purpose of This Appointment_____
_____

Development History: At what age did the child...?

Smile:	Stand:	Walk alone:	Crawl:	Hold object with hands:
Hole head up:	Sit alone:	Talk:	Follow object with his/ her eyes:	

Has this child ever suffered form: (circle all that apply)

Dizziness	Behavioral problems	Arm problems	'Growing pains'
Diabetes	Backaches	Ruptures/hernias	Stomachaches
Anemia	Headaches	Blood disorders	Chronic earaches
Poor appetite	Digestive disorders	Heart troubles	Cold/Flu
Bed wetting	Rheumatic fever	Diabetes/hypoglycemia	Allergies
Fainting	Hyperactivity	Paralysis	Constipation
Neck problems	Seizures	Broken bones	Diarrhea
Joint problems	Walking problems	Leg problems	Asthma

*Any other:_____
Surgery_____
Medications_____
Accidents_____
Family History_____
Has your child ever been treated on emergency basis: Y or N If so, why?_____
Do you have any type of health insurance? Y or N if so, Company_____ ID #_____
**Please provide us with your insurance card so we may photocopy.

I agree to assume responsibility for any charges created by the chiropractic care, and give consent for my child to be examined and/or treated by Dr. Marie and her staff.

Parental Signature _____ Date _____

Foundation Chiropractic, P.C.
6245 Emerald Pkwy
Dublin, OH 43016
614-389-5271
www.foundationchirodublin.com

Developmental Milestones
Normal Guidelines

Please indicate the skills your child has accomplished and when they accomplished it, especially noting if they had any problems or delays.

Child's Name: _____ Date _____

DOB: _____ Age: _____ Sex: M F

GROSS MOTOR SKILLS

4 weeks Able to hold head up from the table face down _____
3 mths Head and shoulder supported by the forearms face down _____
4 mths Infant can sit with assistance _____
6 mths Sits unsupported in the upright position _____
6 mths Rolls from a face down to a face up position _____
9 mths Crawls _____
9 mths Stands holding onto furniture _____
11 mths Walks with someone holding onto one hand _____
12 mths Walks unassisted _____
2 years Runs _____

SOCIAL SKILLS

2 mths Smiles _____
3 mths Reaches for familiar objects _____
4 mths Plays with hands _____
6 mths Plays with feet _____
9 mths Clearly shows joy and pleasure _____
12 mths Feeds self with fingers _____
15 mths Plays peek-a-boo _____
18 mths Understands yes and no _____

FINE MOTOR SKILLS

At birth Primitive grasp reflex present _____
4 mths Holds and shakes a rattle placed in the hand _____
5 mths Grasps objects independently _____
6 mths Moves an object from one hand to the other _____
6 mths Checks objects by placing them in the mouth _____
10 mths Feeds from a cup unassisted _____
12 mths Picks up object with thumb and index finger _____
12 mths Holds own bottle _____
15 mths Turns 2 to 3 pages of a book at a time _____
18 mths Turns pages of a book one at a time _____
20 mths Feeds self with utensils _____
24 mths Builds a tower containing at least 5 blocks _____

COMMUNICATION SKILLS

7 weeks Makes cooing sounds _____
3 mths Laughs _____
5 mths Uses one syllable words such as "da" _____
8 mths Uses 2 syllable words such as "dada" _____
12 mths Uses 2 to 3 word vocabulary _____
24 mths Uses 2 to 3 word phrases _____

Foundation Chiropractic, P.C.

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Consent to Treat a Minor Child

Date _____

I Hereby Authorize:

The above named doctor, and whomever he or she may designate as assistants, to administer the required care as deemed necessary to my (indicate relationship of child) _____ (Name of Child) _____.

Signed: _____
Parent or guardian

Witnessed: _____