Pediatric Patient Questionnaire

Confidential Patient Information

Child's Name:	Parent/Guardian Name(s):		
Street Address:	City:	State:	Zip:
Cell Phone:	Home Phone:		
Email:	Child's SS#	Birthdate:	Age:
How did you hear about us?	Height:	Weight:	
Who is your child's 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/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?

Has your child experienced any of the following conditions in the last six months?

[ ] ADD/ADHD/Hyperactivity [ ] Anemia [ ] Arm Problems [ ] Asthma/Allergies [ ] Back aches [ ] Bed Wetting
[ ] Behavioral Problems [ ] Blood disorders [ ] Broken Bones [ ] Car Accident [ ] Chronic Colds [ ] Colic
[ ] Constipation [ ] Diabetes/hypoglycemia [ ] Diarrhea [ ] Ear Infections [ ] Fainting [ ] Growing Pains
[ ] Headache [ ] Heart Trouble [ ] Leg Problems [ ] Neck Pain [ ] Paralysis [ ] Poor Appetite [ ] Recurring Fevers
[ ] Reflux [ ] Ruptures/Hernias [ ] Scoliosis [ ] Seizures [ ] Stomachaches [ ] Temper Tantrum [ ] Toe Walking
[ ] Other _____

Please list any drugs/medications/vitamins/herbs/other that your child is taking:

Please list any food sensitivities, intolerances, or allergies and when they began:

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 _____	[ ] Resolving existing condition
2 _____	[ ] Overall Wellness
3 _____	[ ] Both

Have you ever visited a chiroprator? [ ] Yes [ ] No If yes, what is their name?

PREGNANCY AND FERTILITY HISTORY WITH THIS CHILD

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:
Mother on medications	[ ] 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 and Delivery History

Child's birth was: [ ] Natural vaginal [ ] Scheduled C-section [ ] Emergency C-section

Child's birth was: [ ] At home [ ] At birthing center [ ] At a hospital Midwife/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:

At how many weeks was your child born?

Birthweight: lbs oz Birth height: in. APGAR score at birth: APGAR score after 5 minutes:

Growth and 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?

Do they have any feeding difficulties? [ ] Yes [ ] No If yes, please explain:

Did/does your child ever suffer from colic, reflux, or constipation as an infant? [ ] Yes [ ] No

If yes, please explain:

Do they sleep easily? [ ] Yes [ ] No If no, please explain:

Do they have a preferred sleeping position? [ ] 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 _____ Cross Crawl _____ Stand alone _____

Walk _____ Begin cow's milk _____ Begin solid foods _____ Smile _____

Please list your child's hospitalization and surgical history, including the year:

Please list any major injuries, accidents, falls and/or fractures sustained in the child's lifetime, including the year:

Other traumas not decsribed above? [ ] Yes [ ] No If yes, please explain:

Have you chosen to vaccinate your child? [ ] No [ ] Yes, on a delayed/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:

According to the National Safety Council, approximately 50% of children fall head first from a high place during their first year of life (I.e. a bed, changing table, downstairs, etc.). Was this the case for your child? [ ] 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 [ ] Average [ ] Mostly processed foods

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 Foundation Chiropractic.

Date: _____ Parent Signature: _____