Well.
FAMILY CHIROPRACTIC

PEDIATRIC PATIENT QUESTIONNAIRE

CONFIDENTIAL PATIENT INFORMATION			
Child's Name:	Parent/ Guardian Name(s):		
Street Address:	City, State, Zip:		
Cell Phone:	Other Phone:	Child's Sex: □ M □ F	
E-mail:	Child's SS #:	Birthdate:	Age:
How did you hear about us?		Weight:	Height:
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/ 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

Have you ever visited a chiropractor? □ Yes □ No If yes, what is their name?
What is their specialty? □ Pain Relief □ Physical Therapy & Rehab □ Nutritional □ Subluxation-based □ Other _____

What are your top three health goals for your child?	**What would you like to gain from chiropractic care?**
1. _____	□ Resolve existing condition
2. _____	□ Overall wellness
3. _____	□ Both

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 weeks was your child born?
Child's birth was: □ At home □ At a birthing center □ At a hospital -- 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: Child's birth height: 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:_____ Sit alone: _____ Vocalize:_____ Teethe:_____ 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 TV, a computer, tablet, or phone?
How would you describe your child's diet? □ Mostly whole, organic foods □ Pretty average □ High amounts of processed foods

ACKNOWLEDGEMENT & CONSENT

Child's Guardian Signature: _____ Date: _____