Note: Fill out this questionnaire at your own convenience. Your answers are saved as you go, so you don't need to finish it all in one sitting.

Submit the form only when you have answered all that you can.

Pediatric Patient Application

CONFIDENTIAL PATIENT INFORMATION:

Child's Name:

Date of Birth:

Gender:
○ Male ○ Female

Height (ft, in):

Weight (lbs):

Parent/Guardian Name(s):

Street Address:

Apt./Unit #:

City:

State:

Zip Code:

Cell Phone:

Home Phone:

Work Phone:

Email:

How did you hear about us?

Preferred Method of Contact:
☐ Phone Call ☐ Text Message
☐ Email

4

What other healthcare providers is your child currently receiving care from? Include your pediatrician, if applicable:

	Name	Specialty
1		
2		

5

Our Doctors will recommend care for you based on 2 things...

1. *The Doctors' findings from your first visit*
2. *YOUR health goals*

Please describe what your immediate, short-term and long-term health goals are so our Doctors can put the best plan in place for you.

1. What are your immediate health goals for your child?

2. What are your short-term health goals for your child?

3. What are your long-term health goals for your child?

6

What would you like your child to gain from chiropractic care? (select all that apply)

☐ Achieve current health goals ☐ Overall wellness ☐ prevention

7

Has your child ever visited a chiropractor?

○ Yes ○ No

8

What primary health concern brings your child into our office?

When did this problem first begin?

How did this problem start?

Is this problem:

How often is this present?

Severity:

Have you received care for this problem before?

○ Yes ○ No

How would you describe this problem?

What makes the problem better?

What makes the problem worse?

9

How are your symptoms/conditions interfering with your child's life? (select all that apply)

☐ Impacting their development/milestones ☐ Cannot play like they want ☐ Affecting our relationships ☐ Affecting our sleep and rest

☐ Affecting our energy levels ☐ Limiting their productivity or creativity ☐ Impacting our attitudes and patience

How committed are you to correcting the underlying issues?

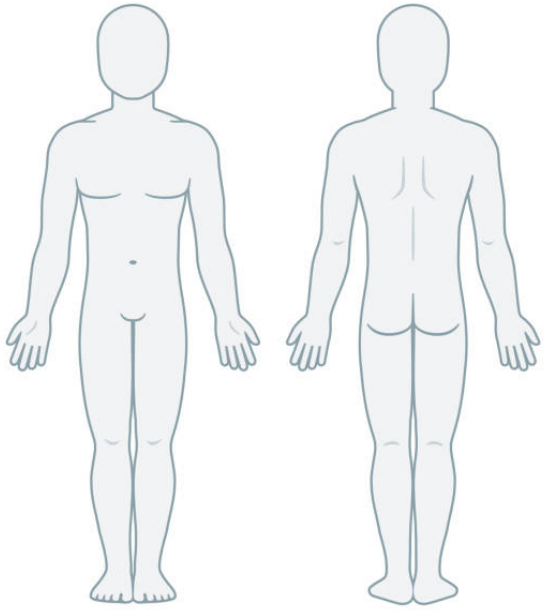
10

	Health Concern	Severity (1 - 10)	How long have you had this?	Did this start with an injury?	Have you had this before?	Constant or Comes/Goes
1						
2						

11

Please indicate where your child is experiencing their primary health concern.

Discomfort | Stiffness | Pain | Numbness/Tingling | Other



12

Is your child currently taking any medications/supplements?

○ Yes ○ No

13

Please list any significant family medical history:

LABOR & DELIVERY HISTORY

If your child is above the age of 5, skip to GROWTH & DEVELOPMENT HISTORY

14

At how many weeks was your child born? | Child's birth was: | They were born:

If other, please specify:

Birth Provider's Name/Location:

Child's birth weight: | Child's birth length:

15

Where there any complications with birth? Please select any and all interventions or complications:

☐ Breech ☐ Induction ☐ Pain meds ☐ Manual Assistance ☐ Epidural ☐ Episiotomy ☐ Vacuum Extraction ☐ Forceps ☐ Cord-Wrapped ☐ Other ☐ NONE

If other, please specify:

16

Do you have any other concerns or notable remarks about your child's labor and/or delivery?

GROWTH & DEVELOPMENT HISTORY

17

How is your child being fed?

Breastfeeding	Bottle or Formula	When did you introduce solid foods?

Did your child have trouble breastfeeding?

If so, what issues?

18

Did/Does your child ever suffer from colic, reflux, skin issues, or constipation as an infant?

○ Yes ○ No

19

Did/Does your child frequently arch their neck/back, feel stiff, or bang their head?

○ Yes ○ No

20

Did your child experience any notable challenges or delays in development?

	Rough Age	Please Explain Any Issues They Encountered
Respond to sound:		
Follow an object:		
Hold their head up:		
Vocalize:		
Teething:		
Sit alone:		
Crawl:		
Walk:		
Begin solid foods:		

21

Any other developmental challenges not listed above?

22

Did/Does your child have any food intolerances or food allergies?

○ Yes ○ No

23

Please list any major injuries, accidents, falls and/or fractures your child has sustained, including the year:

	Injury	Year
1		
2		

24
Please list any of your child's hospitalizations and surgical history, including the year:

	Hospitalization / Surgery	Year
1		
2		

25
Would you like additional resources regarding childhood vaccines?

○ Yes ○ No

26
Did/Does your child have any difficulty sleeping?

27
Did/Does your child have any behavioral, social or emotional challenges?

28
How many hours per day does your child typically spend watching a TV, computer, tablet or phone?

○ Less than 1 hour ○ 1-3 hours daily ○ 3 or more hours daily

29
How would you describe your child's diet? If your child is breastfeeding, how would you describe the mother's diet?

○ Mostly whole, organic foods ○ Pretty average ○ High amount of processed foods

30
Child's hobbies/interests:

31
Are there other health concerns, or is there anything else you'd like us to know about your child?

Please click the right arrow to continue to the next page...

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 your child has experienced - including both past and present.

32

	Past	Present	Briefly Explain Any Issues Experienced
ADHD / ADD / Attention Challenges	☐	☐	
Allergies / Autoimmune Challenges	☐	☐	
Anxiety / Depression / Emotional Instability	☐	☐	
Asthma / Breathing Issues	☐	☐	
Balance / Coordination Issues	☐	☐	
Behavior Issues	☐	☐	
Bladder / Bedwetting / Urination Issues	☐	☐	
Chronic Chest Colds / Cough / Sore Throat	☐	☐	
Colic / Excessive Crying	☐	☐	
Constipation / Loose Stool	☐	☐	
Difficulty Latching / Nursing	☐	☐	
Difficulty Sleeping	☐	☐	
Digestive Problems	☐	☐	
Ear / Sinus Infections	☐	☐	
Frequent Tantrums / Meltdowns	☐	☐	
Gas Pain / Bloating	☐	☐	
Headaches / Migraines	☐	☐	
Lightheadedness / Dizziness	☐	☐	
Back, Neck, Hip, or Shoulder Pain & Stiffness	☐	☐	
Low Energy	☐	☐	
Nausea / Vomiting	☐	☐	
Poor Circulation	☐	☐	
Poor Metabolism / Weight / Blood Sugar Control	☐	☐	
Reflux / Excessive Spit Up	☐	☐	
Sensory Processing Challenges	☐	☐	
Skin Conditions / Rash / Eczema	☐	☐	
Speech / Communication Delays / Challenges	☐	☐	
Swollen Tonsils / Adenoids	☐	☐	
Toe Walking / Altered Gait	☐	☐	
Torticollis	☐	☐	
Vision / Hearing Issues	☐	☐	

ACKNOWLEDGEMENT & CONSENT

By signing this form electronically, and clicking on "Submit Signature", you are agreeing to the terms stated herein.

e-signature
Patient or Parent/Guardian

Signature: Date: