Pediatric Patient Questionnaire

CONFIDENTIAL PATIENT INFORMATION

Child's Name: _____

Parent/Guardian Name(s): _____

Address: _____

City: _____ State: _____ Zip: _____

Cell Phone: _____ Other Phone: _____

Email: Adastra _____

Birthdate: _____ Age: _____ Child's Gender: _____

Who can we thank for your referral? _____

Primary Care Physician: _____

Is your child receiving care from any other health professionals? ☐ Yes ☐ No

If yes, please name them and their specialty: _____

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

Please list your top three health goals for your child:

_____

_____

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

NAME	DOSAGE	REASON FOR TAKING

What would you like to gain from chiropractic care?

☐ Resolve existing condition(s) ☐ Overall wellness ☐ Both

Has your child ever visited a chiropractor? ☐ Yes ☐ No

If yes, what is their name? _____

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? _____ Birth weight: _____ Birth height: _____

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 conception, pregnancy, labor and/or delivery:

_____

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: _____

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 their lifetime (including the year):

_____

Have you chosen to vaccinate your child?

☐ No ☐ Yes, on a delayed/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 Explain: _____

Behavior, social, or emotional issues? ☐ Yes ☐ No Explain: _____

How would you describe your child's diet?

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

ACKNOWLEDGEMENT & CONSENT

I certify that I understand that providing a full health history is imperative for the doctor(s) to make the best plan and choices for care. I affirm that I have thoroughly and honestly completed these intake forms to the best of my ability. I acknowledge that a comprehensive evaluation is necessary to determine the next steps most appropriate in this case.

Parent/Guardian Signature: _____ Date: _____