PRINCIPLED CHIRO
Health From Within

Pediatric Patient Questionnaire

Today's Date _____

Child's Name_____ Parent(s)/Guardian(s) Name_____

Address_____ City_____ State_____ Zip_____

Home Phone_____ Work Phone_____ Mobile_____

Is it ok to contact you at work? ☐ No ☐ Yes

Email_____ Birthdate_____ Age_____

Have you or your child ever had chiropractic care before? ☐ No ☐ Yes

If yes, please tell us your doctor's name _____

Were you pleased with care? ☐ No ☐ Yes

How did you find out about our office? _____

Is this appointment related to an auto accident? ☐ No ☐ Yes

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

If yes, please name them and their specialty _____

_____

Who is your family's primary care physician? _____

Please list any medications your child is taking _____

_____

Please list any vitamins/herbs/homeopathics your child is taking _____

_____

Please list any allergies your child has _____

_____

What health condition brings your child to our office? _____

_____

When did the symptom first begin? _____

How did the problem start? ☐ Suddenly ☐ Gradually ☐ Post-Injury

Is this condition ☐ Improving ☐ Getting Worse ☐ Intermittent ☐ Constant ☐ Not Sure

What makes the problem better? _____

What makes the problem worse? _____

Has your child ever had a similar condition in the past? ☐ No ☐ Yes

Please explain _____

Has your child ever been treated for this problem before? ☐ No ☐ Yes

Please explain _____

Does your child eat well? ☐ No ☐ Yes Does your child have regular bowel movements? ☐ No ☐ Yes

Has your child ever been checked for vertebral subluxations? ☐ No ☐ Yes ☐ Don't know

Was your child born ☐ At Home ☐ At a Birthing Center ☐ At a Hospital

My obstetrician/midwife/family physician was _____

Child's birth was ☐ Natural Vaginal (no medications/no interventions)
☐ Vaginal with interventions
☐ Induction ☐ Pain Medication ☐ Epidural ☐ Episiotomy ☐ Vacuum Extraction
☐ Forceps ☐ Amniocentesis ☐ Other _____
☐ C-section If yes: ☐ Scheduled ☐ Emergency

Please list reasons for interventions/complications _____

_____

Was the umbilical cord wrapped around neck? ☐ No ☐ Yes

Child's birth weight/height _____ Current weight/height_____

APGAR score at birth _____ APGAR score at 5 minutes _____

Was your child alert and responsive within 12 hours of birth? ☐ No ☐ Yes

If no, please explain _____

At what age did your child:

Respond to sound _____ Follow an object _____ Hold head up _____ Sit alone _____ Teethe _____

Crawl _____ Walk _____ Speak _____

Please list any hospitalizations or surgeries (including year): _____

_____

Please list any major injuries, accidents, falls, and/or fractures your child has sustained in his/her lifetime

_____

_____

Is/was your child breastfed? ☐ No ☐ Yes If yes, how long?_____

Did your child have challenges with nursing? ☐ No ☐ Yes If yes, please explain: _____

_____

Formula introduced at what age? _____ What type? _____

Introduction of cow's milk at age_____ Began solid foods at age _____

Please list any food intolerances _____

Did mother smoke during pregnancy? ☐ No ☐ Yes

Did mother consume alcohol during pregnancy? ☐ No ☐ Yes

Any illness of mother during pregnancy? ☐ No ☐ Yes

If yes, please explain treatment/medication/supplements _____

_____

Please list any drugs/medications (including over the counter) taken during pregnancy _____

_____

List any supplements taken regularly during pregnancy _____

_____

Any exposure to ultrasound? ☐ No ☐ Yes If yes, how many and what was the medical reason? _____

_____

Has the child received any vaccinations? ☐ No ☐ Yes If yes, which ones and list any reactions: _____

_____

_____

Has your child received any antibiotics? ☐ No ☐ Yes If yes, how many times and for what reasons?____

_____

Any difficulty with bonding? ☐ No ☐ Yes If yes, please explain: _____

_____

Any behavioral problems? ☐ No ☐ Yes If yes, please explain:_____

_____

Any night terrors, sleepwalking, or difficulty sleeping? ☐ No ☐ Yes If yes, please explain:_____

_____

Age child began daycare: _____ Average number of hours watching TV each week _____

Does your child seem normal for their age? ☐ No ☐ Yes If no, please explain:_____

_____

Family Health History: Check those involving immediate family and add identification:

M= Mother F= Father S= Siblings G= Grandparent

☐ Cancer, type_____ ☐M ☐F ☐S ☐G	☐ Depression ☐M ☐F ☐S ☐G	☐ Diabetes ☐M ☐F ☐S ☐G	☐ Back Problems ☐M ☐F ☐S ☐G
☐ Heart Disease ☐M ☐F ☐S ☐G	☐ Liver Disease ☐M ☐F ☐S ☐G	☐ High Blood Pressure ☐M ☐F ☐S ☐G	☐ High Cholesterol ☐M ☐F ☐S ☐G
☐ Lung Problems ☐M ☐F ☐S ☐G	☐ Scoliosis ☐M ☐F ☐S ☐G	☐ Neck Problems ☐M ☐F ☐S ☐G	☐ Osteoporosis ☐M ☐F ☐S ☐G
☐ Seizures ☐M ☐F ☐S ☐G	☐ Osteoarthritis ☐M ☐F ☐S ☐G	☐ Rheumatoid Arthritis ☐M ☐F ☐S ☐G	

☐ Other _____

_____

Do you know what subluxation is? ☐ No ☐ Yes

Do any of your friends or relatives see a chiropractor? ☐ No ☐ Yes

If yes, do they use chiropractic for ☐ Health maintenance/optimization ☐ Health problems ☐ Both

Are you seeking chiropractic for ☐ Health maintenance/optimization ☐ Health problems ☐ Both

What would you like to gain from chiropractic? _____

_____

Are there any other health concerns or anything else you would like us to know about your child? _____

_____

_____

The above is accurate to the best of my knowledge

_____ _____

Signature *Date*

I, parent/guardian, give permission for my minor's care

_____ _____

Signature *Date*

PRINCIPLED CHIRO *Health From Within*

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