

Pediatric Patient Questionnaire

Confidential Patient Information

Child's Name:	Parent/Guardian Name(s):		
Street Address:	City, State, Postal Code:		
Cell Phone:	Other Phone:	Child's Sex:	
Email:	Child's SSN:	Birthdate:	Age:
How did you hear about us?	Height:	Weight:	
Who is your primary care physician?			
Is your child receiving care from any other health professionals? <input type="radio"/> Yes <input type="radio"/> No – If yes, please name them and their specialty:			
Please list any drugs/medications/vitamins/herbs or 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? 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

What are your top three health goals for your child? _____ What would you like to gain?

1. _____ Resolve existing condition

2. _____ Overall wellness

3. _____ Both

Has your child ever visited a chiropractor? Yes No – If yes, what is their name: _____

– What is their specialty: Pain Relief Physical Therapy & Rehab Nutrition Subluxation-based Other: _____

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 often? _____

Did mother drink? Yes No If yes, how often? _____

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 noticeable 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?

Where was your child born? _____ – Who delivered your baby? _____

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 labor and/or delivery:

Child's birth weight: _____ Child's birth height: _____ APGAR score at birth: _____ APGAR score after 5 min.: _____

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: _____

At what age did the child: Respond to sound: _____ Follow an object: _____ Hold their head up: _____ Vocalize: _____

Teeth: _____ Sit alone: _____ 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 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 – 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, computer, tablet or phone? _____

How would you describe your child's diet? Mostly whole, organic foods Pretty average High amount of processed foods

Acknowledgement & Consent

Parent/Guardian Signature: _____

Date: _____

All Star Family Chiropractic

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