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? ◯ Yes ◯ 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?

1. ______
2. ______
3. ______

What would you like to gain?

◯ Resolve existing condition
◯ Overall wellness
◯ 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 noticable 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:______
Teethe:______ 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: ____________

Resilient Life Chiropractic
101 S River Rd, N. Manchester, IN
resilientlifechiro@gmail.com | resilientlifechiro.com

© WELL ALIGNED | WWW.WELLALIGNED.COM