Straight Up Chiropractic

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Pediatric Patient Questionaire

Patient Information

Child's Name ______________________ Parent(s)/Guardian(s) Name ______________________

Address ______________________ City ______________ State _____ Zip __________

Home Phone ______________ Work Phone ______________ Cell Phone ______________

Is it okay to contact you at work? ( ) Yes ( ) No

E-mail ______________ Child's Social Security # __________ Birthdate ________ Age_____

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

If yes, please tell us the doctor's name ______________________

Were you pleased with your care? ☐ Yes ☐ No

How did you find out about our office? ______________________

Is this appointment related to an auto accident? ( ) Yes ( ) No

Is your child receiving care from other health professionals? ( ) Yes ( ) No

If yes, please name them and their specialty ______________________

Who is your family's primary care physician? ______________________

Please list any drugs or medications your child is taking ______________________

____

Please list any vitamins/herbs/homeopathics/other your child is taking ______________________

____

Please list any allergies your child has ______________________

____

Current Health

Most children in our office are here for enhanced development and optimal function for body and mind.

What health condition brings your child to our office? ______________________

____

When did the symptoms first begin? ______________________

How did the problem start? ( ) Suddenly ( ) Gradually ( ) Post-Injury

Is this condition ( ) Getting Worse ( ) Improving ( ) Intermittent ( ) Constant ( ) Not Sure

What makes the problem better? ______________________

What makes the problem worse? ______________________

Has your child ever had a similar condition? ( ) Yes ( ) No

Please explain ______________________

Has your child been treated for this problem before? ( ) Yes ( ) No

Please explain ______________________

Does your child eat well? ( ) Yes ( ) No Does your child have regular bowel/bladder movements? ( ) Yes ( ) No

Has your child ever been checked for vertebral subluxations? ( ) Yes ( ) No ( ) Don't Know

Health History

Child's birth was ( ) At home ( ) At a birthing center ( ) At a hospital

My obstetrician/midwife/family physician was ____

Child's birth was ( ) Natural vaginal (no medications/interventions)

( ) Vaginal with interventions

( ) Induction ( ) Pain medication ( ) Epidural ( ) Episiotomy ( ) Vacuum extraction ( ) Forceps

( ) Other ____

( ) C-section ( ) Scheduled ( ) Emergency

Please list reasons for any interventions/complications ____

____

Child's birth weight ________ Child's birth height _________ Current weight ________ Current height ________

APGAR score at birth ________ APGAR score after 5 minutes _________

Growth and Development

Was your child alert and responsive within 12 hours of delivery? ( ) Yes ( ) No

If no, please explain ____

At what age did the child

Respond to sound ____________ Follow an object _____________ Hold head up ___________ Vocalize __________

Sit alone _____________ Teethe __________ Crawl ________ Walk ______________

Patient/Hospitalization/ Surgical (please list below all surgeries and hospitalizations, including the year)

____

____

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

____

____

Is/was your child breastfed? ( ) Yes ( ) No If yes, how long? ___________

Formula introduced at age ____________ What type? _______________________

Introduction of cow's milk at age _______ Began solid foods at age ____________

Please list any foods/juice intolerance ____

Did mother smoke during pregnancy? ( ) Yes ( ) No

Did mother drink alcohol during pregnancy? ( ) Yes ( ) No

Any illness of mother during pregnancy? ( ) Yes ( ) No

If yes, please explain including treatment/medications/supplements ______________________________

____

List any drugs/medications (including over the counter) taken during pregnancy ______________________________

____

List any supplements taken during pregnancy ____

Any exposures to ultrasound? ( ) Yes ( ) No If so, how many and what was the medical reason? ____________________

____

Any pets at home? ( ) Yes ( ) No Any smokers at home? ( ) Yes ( ) No

Growth and Development

Has child received any vaccinations? ( ) Yes ( ) No If yes, which ones and list any reactions ______________________________

____

Has child received any antibiotics? ( ) Yes ( ) No If yes, how many times and list reasons ______________________________

____

Any difficulty with breastfeeding? ( ) Yes ( ) No If yes, please explain ______________________________

____

Any difficulty with bonding? ( ) Yes ( ) No If yes, please explain ______________________________

____

Any behavioral problems? ( ) Yes ( ) No If yes, please explain ______________________________

____

Any night terrors, sleepwalking or difficulty sleeping? ( ) Yes ( ) No If yes, please explain ______________________________

____

Age child began daycare______________ Average number of hours of TV per week ______________

Does your child seem normal for their age? ( ) Yes ( ) No If no, please explain.______________________________

____

Family History

Check those involving immediate family and add identification: M=Mother, F=Father, S=Sibling, G= Grandparents

☐ 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 ____

____

Chiropractic

Do you know what subluxation is? ( ) Yes ( ) No

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

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 care? ______________________________

____

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

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