WELCOME

Date _____

Child's Name _____ Male / Female

DOB _____ Age_____ SSN#_____- _____- _____

Mother's Name_____ Father's Name_____

Number of Siblings: _____

Address _____City_____State_____Zip_____

Home Phone _____Cell _____ Work Phone_____

Email _____

Mother's Employer: _____

Father's Employer: _____

How were you referred to our office? _____

RESPONSIBLE PARTY (IF DIFFERENT FROM ABOVE)

Name _____
Address _____City_____State_____Zip_____
Home Phone_____Cell_____Work_____

*** NOTICE ***

Although we are providers for many insurance carriers, we CANNOT GUARANTEE PAYMENT OR COVERAGE of chiropractic services. If you would like to know details regarding payment under your specific insurance plan, please contact your insurance provider.

Signature:_____

Date: _____

Pediatric Health Questionnaire

Current Complaints:

(1) _____How long? _____
(2) _____How long? _____
(3) _____How long? _____

Has your child ever received chiropractic care? YES / NO When? _____

Health History:

( ) Neck pain / stiffness
( ) Headaches / migraines
( ) Ear aches / infections
( ) Sore throats
( ) Shortness of breath / bronchitis
( ) Pain between shoulders
( ) Low back pain
( ) Hip pain
( ) Fatigue / sleep problems
( ) Stomach problems / constipation
( ) Bed wetting
( ) Joint stiffness
( ) Numbness/tingling in extremities, fingers or toes
( ) Colic
( ) Fevers
( ) Depression
( ) Dizziness
( ) Hyperactivity
( ) Allergies / Asthma
( ) Reflux

Has your child been under medical care? If so, for what condition and how long?

_____

Medications? _____
Surgeries? If so, when? _____

Problems During Pregnancy?_____
Third Trimester Presentation: (please circle one) VERTEX / BREECH / TRANSVERSE / FACE or BROW
Problems During Labor/Delivery? _____
Long delivery? YES / NO Difficult delivery? YES / NO Induction? YES / NO
Caesarean delivery? YES / NO Forceps/vacuum extraction? YES / NO

Birth Location: (please circle one) HOME / BIRTHING CENTER / HOSPITAL
Is your child vaccinated? YES / NO
Number of Doses of Antibiotics Taken: Past 6 months _____ During His/Her Lifetime_____

Is/Was Your Child BREAST FED or FORMULA FED? (please circle one)
If FORMULA, which one? _____
Number of Hours Sleeping Per Night?_____ Quality of Sleep?(please circle one) GOOD / FAIR / POOR
Sleeping Posture? (please circle one) SIDE / STOMACH / BACK

Does your child eat healthy? YES / NO Special Diet/Food restrictions? _____
Has your child been in any accidents? YES / NO Sports injuries? YES / NO

Circle words describing your child's condition:

constant	pinching	painful
comes / goes	shooting	knife-like
sharp	stiff	tight
dull	sore	tender
achy	weak	mild
throbbing	jolting	moderate
pounding	pressure	intense
burning	numbness	severe
piercing	tingling	other_____

Circle areas of pain on the figure below: