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Pediatric Chiropractic Health Questionnaire

Patient Name:____ Date:_______________________________

Date of last: Physical Exam____________________Spinal X-ray________________Blood test__________________
Spinal exam_____________________ X-ray, MRI, CT, bone scan______________________________________

Accidents or injuries: (Include Date)_________________________________ ____________________________________

Surgeries or Hospitalizations: (Include Date)____

Other Medical Procedures: ____

Name and dosages of medications or supplements____
____

Immunizations:____
____
Allergies:____

Pharmacy Name_________________________________City, Phone____

Sleep_______ hrs/night Naps______#/day _______mins or hours /nap

Sleep pattern regular or irregular: Please explain____

Smokers in the home: Yes___ No___ who?________ Pets in the Home: Yes___ No___

O Daycare O Preschool O School O Home Started at what age?____

HISTORY OF PREGNANCY

Any illnesses of the mother during pregnancy?_ Yes or No ____

O Abnormal Bleeding O High Blood Pressure O Trauma O Infection O Rupture O Diabetes O Swollen Ankles

Any supplements or medication during pregnancy?__ Yes___ No ___ List:______________________________

Any smoking/drugs/chemical exposure during pregnancy? Yes ___ No___

Number of ultrasounds___ Reason:____

Stress level (circle): No stress -1 2 3 4 5 6 7 8 9 10- Extremely Stressed

HISTORY OF BIRTH

Place of delivery: ___________________________________Hospital/Birthing Center/Home Birth

Name of Prenatal care Provider:___________________________________ OB/MD/Midwife/Other

Duration of Gestation:__________________Duration of labor:_________Hours/Days

Birth weight/ length:_____lbs______oz ______inches

Complications of labor or delivery:____

Check off the following that describes your child's birth:

◯ Long and / or difficult	◯ Epidural
◯ Forceps	◯ Breech
◯ Vaccum extraction	◯ Induced
◯ Caesarean	◯ Unmedicated/Unassisted

Was your child alert and responsive within 12 hours of delivery: Yes or No

Please explain: ____

Any birth trauma including bruising/fractures/getting stuck in birth canal:_____________________________

Breastfed/Formula Fed and for how long:____

When did the child meet these milestones:

Sitting Up: _____ Months or Never	Potty Trained_____ Months/Year or Never
Grasping_____ Months or Never	Dry at Night ______Months/Year or Never
Crawling ______Months/Year or Never	First Words ______Months/Year or Never
Pulled to Stand_____ Months or Never	Spoke Simple sentences______Months/Year or Never
Walked Unassisted_____ Months or Never	Spoke clearly______Months/Year or Never

Conditions: Please check any that apply to you:

○ Anemia	○ Ear Infections	○ Liver disease	○ Thyroid problems
○ Appendicitis	○ Epilepsy	○ Measles	○ Tonsillitis
○ Asthma	○ Flu	○ Migraine headaches	○ Tuberculosis
○ Bleeding Disorders	○ Fractures	○ Mononucleosis	○ Tumors, growths
○ Bronchitis	○ Glaucoma	○ Mumps	○ Ulcers
○ Cancer	○ Goiter	○ Pink Eye	○ Whooping cough
○ Chemical Dependency	○ Heart Disease	○ Pneumonia	○ Other:__________
○ Chicken Pox	○ Hepatitis	○ Psychiatric care	____________________
○ Colic	○ Herpes	○ Rheumatic fever	____________________
○ Diabetes	○ HIV positive	○ Scarlet fever	____________________
	○ Kidney disease		____________________

Does/Did any of your immediate family members have any health conditions:

____

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General Symptoms: Check any symptom you currently have or had in the past.

General
- ◯ Attention disorder
- ◯ Bruise easily
- o Chills
- o Difficulty sleeping
- o Dizziness
- o Fainting
- o Fever
- o Headache
- o Loss of sleep
- o Loss of weight
- o Nervousness
- o Numbness
- o Sweats Day/Night
- o Tiredness
- o Weight gain

Genito-Urinary
- o Blood in urine
- o Frequent Urination
- o Lack of bladder control
- o Painful Urination
- o Yeast Infection
- o Urinary Tract Infections

Gastro-intestinal
- o Poor appetite
- o Bloating
- o Bowel changes
- o Colic
- o Constipation
- o Diarrhea
- o Excessive hunger
- o Excessive thirst
- o Gas
- o Hemorrhoids
- o Indigestion
- o Nausea
- o Rectal bleeding
- o Stomach pain
- o Vomiting
- o Vomiting blood

Other Health Conditions:____
____
____
____
____

Eye, ears, nose throat
- o Bleeding gums
- o Blurred vision
- o Crossed eyes
- o Difficulty swallowing
- o Double vision
- o Earache
- o Ear Infection
- o Ear discharge
- o Hay fever
- o Hoarseness
- o Loss of hearing
- o Nosebleeds
- o Persistent cough
- o Ringing in ears
- o Sinus problems
- o Vision-flashes
- o Vision-halos

Skin
- o Bruise easily
- o Hives
- o Itching
- o Change in moles
- o Rash
- o Scars
- o Sores that won't heal

Cardiovascular
- o Chest pain
- o Irregular heart beat
- o Low blood pressure
- o Poor circulation
- o Rapid heart beat
- o Swelling of ankles
- o Varicose veins

Neck, Back and Extremities Check symptoms you are currently having or have had in the past year.

Neck
- o Pain in neck
- o Neck Stiffness
- o Pinched nerve
- o Neck feels out of place
- o Muscles spasms in neck
- o Grinding/popping sounds in neck

Shoulders
- O Pain in Shoulder joint O Right O Left
- o Pain across Shoulders
- o Can't raise arm O Right O Left
- o Tension in shoulders
- o Pinched nerve in shoulder O Right O Left

Mid-back
- o Mid-back pain
- o Mid- back stiffness
- o Pain between shoulder blades
- o Pain from front to back
- o Muscle spasms in mid-back

Arms and hands
- o Pain in upper arm O Right O Left
- o Pain in elbow O Right O Left
- o Pain in forearm O Right O Left
- o Pain in hand O Right O Left
- o Pain in fingers
- o Pins and needles in arm O Right O Left
- o Pins and needles in fingers O Right O Left
- o Weakness in arms O Right O Left
- o Weakness in hands O Right O Left
- o Hands are cold O Right O Left

Low back
- o Low back pain
- o Low back stiffness
- o Low back weakness
- o Pinched nerve in back
- o Low back feels out of place
- o Muscle spasms in back
- o Sciatic pain

Hips, legs and feet
- o Pain in buttocks O Right O Left
- o Pain in hip joint O Right O Left
- o Pain down leg O Right O Left
- o Pain in knee O Right O Left
- o Pain in ankle O Right O Left
- o Pain in foot O Right O Left
- o Weakness in leg O Right O Left
- o Weakness in knees O Right O Left
- o Leg cramps O Right O Left
- o Pins and needles O Right O Left
- o Other Symptoms________________________
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I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any member of her staff responsible for any errors or omission that I may have made in the completion of this form.

Patient/Guardian Signature ____ Date: ___________