WELCOME

Date _____

Child's Name _____ Gender: Male / Female

Date of Birth _____ Age _____ SSN _____-_____-_____

Mailing Address _____ Unit/Apt # _____

City _____ State _____ Zip _____

Primary Phone _____ Secondary Phone _____

Email: _____ Number of Siblings _____

Mother's Name _____ Father's Name _____

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

I agree to promptly notify my provider of any changes in my health insurance plan and/or coverage including changes to my address and/or phone number. I understand that my failure to do so will make me fully responsible for the entire bill as this is not the responsibility of the Provider. I understand that the provider will bill my insurance as a courtesy to me and I am financially responsible for all treatment charges whether the insurance company pays or not. This includes, but is not limited to, deductible, co-insurance, co-pays, non-covered services or out-of-network services.

Parent/Guardian 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
( ) Colic
( ) Fatigue / sleep problems
( ) Stomach problems / constipation
( ) Bed wetting
( ) Joint stiffness
( ) Numbness/tingling in extremities, fingers or toes
( ) Fevers
( ) Depression
( ) Dizziness
( ) Hyperactivity
( ) Allergies / Asthma
( ) Reflux
( ) Hip pain

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: (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: