PEDIATRIC QUESTIONNAIRE

(5 YEARS AND UNDER)

New Patient ☐
Reactivate ☐
Other ☐

***Full Legal Name** _____ ***Birth Date** _____
First *Middle* *Last*

***Address** _____
Street / PO Box *City* *State* *Zip*

Mother Name _____ Father Name _____

Address _____ Address _____

Home Phone _____ Home Phone _____

Mobile Phone _____ Mobile Phone _____

Email _____ Email _____

Would you like to receive Email or Text reminders for appointments? ☐ No ☐ Yes – ***(*Please sign Authorization form at office)***

Emergency Contact _____ Phone # _____ Relationship _____

***Did anyone refer child to our office**? ☐ No ☐ Yes – Who _____

HISTORY OF PRESENTING ILLNESS/INJURY *(see also page 3)*

***What are child's symptoms?** _____

***How did it occur?** _____

Date child's symptoms began?** _____ ☐ ***Auto Accident** ***(*Provide copies of ALL Documents)

***Are there any recent X-rays of that area(s)?** ☐ No ☐ Yes – Facility where taken? _____

PAST MEDICAL HISTORY *(see also page 4)*

***Has child received care from a Chiropractor before?** ☐ No ☐ Yes – Doctor/Clinic _____

INSURANCE COVERAGE

Insurance?** ☐ No ☐ Yes - ***Provide COPY of Insurance Card(s)

CLINIC USE ONLY:

Appointment Date _____ *Time* _____ *am / pm*

Clinic _____ *Provider* _____

Patient Acct # _____ *Staff Initials* _____

PRIMARY INSURANCE	SECONDARY INSURANCE
Insurance Co _____	Insurance Co _____
Insurance Phone _____	Insurance Phone _____
Policy/Subscriber ID# _____	Policy/Subscriber ID# _____
Group# _____	Group# _____
Policyholder Name _____	Policyholder Name _____
Policyholder Relationship to Child _____	Policyholder Relationship to Child _____
Policyholder Date of Birth _____	Policyholder Date of Birth _____
Policyholder Employer _____	Policyholder Employer _____

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PATIENT DEMOGRAHICS *(*Required per Federal Guidelines)*

SSN# _____-_____-_____

***Gender** ☐ Male ☐ Female

Ethnicity *(select one): ☐ Hispanic ☐ Not Hispanic

Race *(select one):

☐ Alaska Native ☐ Asian ☐ Native Hawaiian ☐ White/Caucasian
☐ American Indian ☐ Black/African American ☐ Other Pacific Islander ☐ Other: _____

Language *(select one):

☐ English ☐ Hmong ☐ Lao ☐ Spanish ☐ Vietnamese ☐ Other: _____

How do you prefer to receive follow-up reminders for Preventive Care? *(select one) (see page 1)

☐ Letter ☐ Phone Call ☐ Email ☐ Fax

***Allergies:** ☐ None **-OR-** ☐ See List Below:

Drug/Medication (ADR):	*Food:*	*Other Allergies (e.g.-animals, pollen, latex, etc)*

***Current Prescription Medications** ☐ None – **OR** – ☐ See List Below

Name of Prescription:	*Dose (mg, mL, etc)*	*Form (Tab, Caps, etc)*	*Duration (# times per day, wk, mo)*	***-AND-*** *Chronic*	*As Needed*	*Unknown*
			____x per_____			
			____x per_____			
			____x per_____			
			____x per_____			
			____x per_____			
			____x per_____			
			____x per_____			
			____x per_____			
			____x per_____			
			____x per_____			
			____x per_____			
			____x per_____			
			____x per_____			

CLINIC USE ONLY: ***(Vitals age 2 yrs+)***

Height _____ inches; Weight _____ lbs; Pulse _____ ; Respir _____ ; Temp _____ ;

Blood Pressure (Left Arm / Right Arm) _____/_____ (Sitting / Standing / Supine) **Staff Initials:** _____

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HISTORY OF PRESENT ILLNESS - CHIEF COMPLAINT(S)

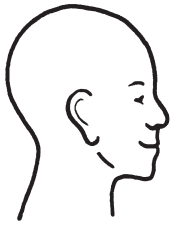
(see also page 1)

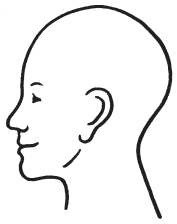
Fill out this section as accurately as possible. Mark the area with the described sensation using the appropriate symbols from the left. Rate your pain on the scale below from 0 to 100 (0 = no pain; 100 = intolerable pain). If there is more than one area of discomfort, please rate the pain 0 to 100 next to each area as appropriate.

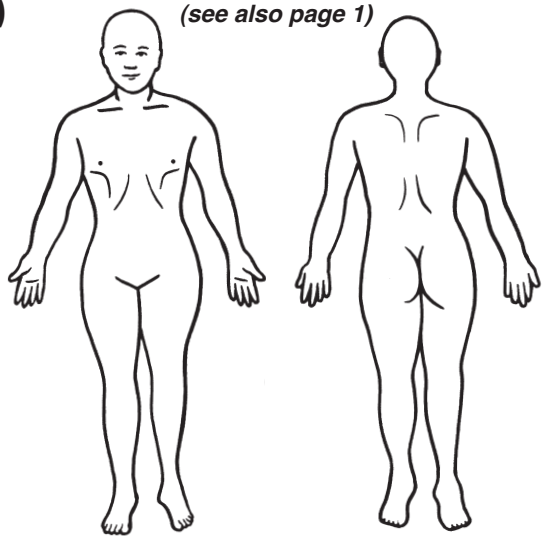
__ Constant
__ Comes/Goes

__ Getting Better
__ Getting Worse
__ Staying Same

Better:	**Worse:**
___ AM	___
___ MID-DAY	___
___ PM	___







NO PAIN **PAIN SCALE:** **INTOLERABLE**

0 ___ 5 ___ 10 ___ 15 ___ 20 ___ 25 ___ 30 ___ 35 ___ 40 ___ 45 ___ 50 ___ 55 ___ 60 ___ 65 ___ 70 ___ 75 ___ 80 ___ 85 ___ 90 ___ 95 ___ 100

What have you tried so far to remedy the problem(s):_____

Was child's delivery: ☐ On Time ☐ Early ☐ Late

Explain: _____

Was the child's delivery: ☐ Vaginal ☐ Cesarean (c-section)

How long was labor: _____

Was the child born: ☐ at home ☐ in hospital

Name of Midwife/Doctor: _____

What was your child's APGAR score _____/10 at birth _____/10 five minutes after birth

Were extraction aids (forceps/suction) used? No Yes
If YES, explain_____

Was there more than one fetus? No Yes
If YES, explain_____

Did the mother use any alcohol or smoke during pregnancy? No Yes
If YES, how much & how often _____

Is/Was your child vaccinated? No Yes
If YES, describe any adverse reactions _____

Is/Was your child breastfed? No Yes
If YES, describe any difficulties _____

Does child have preferred side or head position for sleeping, riding in car seat, breastfeeding? No Yes
If YES, describe _____

Did/Does your child use formula? No Yes
If YES, describe any difficulties/allergies _____

Is your child meeting their developmental milestones? No Yes
If NO, explain _____

Any recent loss of appetite or change in eating habits No Yes
If YES, describe _____

Any recent change in bathroom habits? No Yes
If YES, describe _____

Any change in sleeping habits? No Yes
If YES, describe _____

Does child have preferred sleeping position in bed? No Yes
If YES, describe _____

Any bumps/scrapes/cuts? No Yes
If YES, describe _____

Any recent fevers of unknown origins? No Yes
If YES, describe _____

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PAST MEDICAL HISTORY *(see also page 1)*

How often has child had this condition in the past? ☐ Never ☐ 1-3 Times ☐ 4 or More Times

Has child seen a Medical Doctor for this Condition? ☐ No ☐ Yes – Doctor/Clinic _____

Does child have any other Health Conditions? (Check all that apply):

☐ Diabetes ☐ Asthma ☐ IBS/Colitis ☐ Cancer

☐ Other: _____

Describe any major Illnesses, Injuries, Falls, Hospitalizations, Accidents or Surgeries:

DATE	DOCTOR	CONDITION(S)	RESULTS
_____	_____	_____	☐ Full Recovery ☐ Complications
_____	_____	_____	☐ Full Recovery ☐ Complications
_____	_____	_____	☐ Full Recovery ☐ Complications
_____	_____	_____	☐ Full Recovery ☐ Complications
_____	_____	_____	☐ Full Recovery ☐ Complications
_____	_____	_____	☐ Full Recovery ☐ Complications

SOCIAL HEALTH HISTORY

Recreational Activities/Hobbies_____

Does child consume Caffeine? ☐ No ☐ Yes – How Much? _____ How Often?_____

FAMILY HEALTH HISTORY

List any current or past health conditions of family members (if deceased, indicate at what age and from what?)

MOTHER:_____

FATHER:_____

BROTHERS: _____How Many_____

SISTERS:_____How Many_____

SYSTEM REVIEW QUESTIONS

Does child have problems with the following areas Now or in the Past? (**Y** = Yes and **N** = No)

___**Eyes** (Glasses, Etc)

___**Ears** (Ear Infections, Hearing, Etc)

___**Mouth, Nose, Throat** (Sinuses, Etc)

___**Cardiovascular** (Heart, Etc)

___**Respiratory** (Lungs, Breathing, Asthma, Etc)

___**Neurological** (Nerve Issues, Weakness, Numbness, Etc)

___**Endocrine** (Thyroid, Imbalances, Liver, Etc)

___**Gastro-Intestinal** (Colic, Acid Reflux, Etc)

___**Genito-Urinary** (Male/Female Reproductive, Kidney, Bladder, Etc)

___**Musculoskeletal** (Breaks, Etc)

___**Skin** (Rashes, Dryness, Psoriasis, Eczema, Hair, Etc)

___**Psychiatric** (Anxiety, Depression, ADD/ADHD, Etc)

___**Others:** _____

Please describe in more detail: _____

NOTES

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