



# Chiropractic Pediatric Health Questionnaire

Welcome to our office! It is well known that families who maintain healthy, properly functioning spines have improved health and long lasting vitality. People whose spines are not functioning correctly are more likely to develop health disorders, immune compromise such as getting sick easier or allergies, pain, low energy, arthritis, and set themselves up for even worse health challenges.

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Sex: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Mother: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Mother Address:  Same As Above  
\_\_\_\_\_

Father: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Father Address:  Same As Above  
\_\_\_\_\_

Siblings Names: _____	Age: _____	Sex: _____
_____	Age: _____	Sex: _____
_____	Age: _____	Sex: _____
_____	Age: _____	Sex: _____

Main reason for consulting our office today?  
\_\_\_\_\_  
\_\_\_\_\_

Are you here for any of the following?  Auto Accident  Sport Injury  Other: \_\_\_\_\_

## Personal History

The human body is designed to express health and function normally. However events may occur in life, which can interfere with this natural ability. The interference is most commonly the result of vertebral subluxations. Stress that maybe physical, chemical or emotional may cause these subluxations. The practice of chiropractic is based on the location and reduction of nerve system interference caused by the vertebral subluxation.

## Pregnancy

Please check any areas that applied to the patient's mother during her pregnancy:

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Complication       | <input type="checkbox"/> Premature Contraction | <input type="checkbox"/> Hospitalization      |
| <input type="checkbox"/> Medication         | <input type="checkbox"/> Back Pain             | <input type="checkbox"/> Immunization         |
| <input type="checkbox"/> Recreational Drugs | <input type="checkbox"/> Other Pain            | <input type="checkbox"/> Carried to Full Term |
| <input type="checkbox"/> Smoking            | <input type="checkbox"/> Excessive Weight Loss | <input type="checkbox"/> Bleeding             |
| <input type="checkbox"/> Alcohol            | <input type="checkbox"/> Excessive Weight Gain | <input type="checkbox"/> Physical Trauma      |
| <input type="checkbox"/> Caffeine           | <input type="checkbox"/> Toxic Exposure        | <input type="checkbox"/> Prenatal Classes     |
| <input type="checkbox"/> Allergic Reactions | <input type="checkbox"/> Mental Trauma         | <input type="checkbox"/> Vitamins/Minerals    |
| <input type="checkbox"/> Chiropractic Care  | <input type="checkbox"/> Any Diagnosed Illness | <input type="checkbox"/> Prenatal Care        |

## Labor, Delivery and Birth

Please check any areas that applied to the patient's mother during her delivery:

- |  |   |                                       |
|--|---|---------------------------------------|
| <input type="checkbox"/> Greater than 12 hours | <input type="checkbox"/> Cesarean           | <input type="checkbox"/> Complication |
| <input type="checkbox"/> Hospital              | <input type="checkbox"/> Fetal Monitor      | <input type="checkbox"/> Home Birth   |
| <input type="checkbox"/> Medication            | <input type="checkbox"/> Premature Delivery | <input type="checkbox"/> Forceps      |
| <input type="checkbox"/> Vacuum Extraction     | <input type="checkbox"/> Other: _____       |                                       |

Details on above: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please check any problems the patient had at birth:

- |                                    |                                  |                                       |
|------------------------------------|----------------------------------|---------------------------------------|
| <input type="checkbox"/> Breathing | <input type="checkbox"/> Nursing | <input type="checkbox"/> Coloring     |
| <input type="checkbox"/> Sleeping  | <input type="checkbox"/> Crying  | <input type="checkbox"/> Jaundice     |
| <input type="checkbox"/> Choking   | <input type="checkbox"/> Colic   | <input type="checkbox"/> Other: _____ |

Details on above: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## Childhood

Please check any problems the patient had during childhood:

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Falls or Injuries | <input type="checkbox"/> Respiratory problems | <input type="checkbox"/> Ear Infection          |
| <input type="checkbox"/> Allergy/Asthma    | <input type="checkbox"/> Bedwetting           | <input type="checkbox"/> Digestive problems     |
| <input type="checkbox"/> Medication        | <input type="checkbox"/> Hyperactivity        | <input type="checkbox"/> Hospitalization        |
| <input type="checkbox"/> Convulsion        | <input type="checkbox"/> Immunization         | <input type="checkbox"/> Extremity or back pain |
| <input type="checkbox"/> Gait problems     | <input type="checkbox"/> Antibiotic use       | <input type="checkbox"/> Medications            |
| <input type="checkbox"/> Other: _____      |   |   |

Details on above: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\*\* If there were an affordable way to get rid of the problem, would you be willing to do what it takes to accomplish this now?  
YES / NO

I hereby authorize this office and its doctors to administer chiropractic care to my son/daughter as they deem necessary. I clearly understand and agree that I am personally responsible for payment of all fees charged by this office.

Parent/Legal Guardian

Date