Pediatric Health History Questionnaire

CONTACT INFORMATION

Child's Name: Parent/Guardian's Name:

Street Address: City: State: Zip:

Cell Phone: Home Phone: Work Phone:

Email: Birthdate:

How did you hear about us?

CURRENT HEALTH CONDITIONS

What health condition(s) brought you to the chiropractor today?

When did this condition begin?

Was the onset (circle) **Gradual** or **Sudden**

Has your child been treated for this condition?
-If yes, please explain:

Is the condition (circle) **Getting worse** **Improving** **Intermittent** **Constant** **Unsure**

What makes the problem better? What makes the problem worse?

Have you ever visited a chiropractor?

PREGNANCY AND FERTILITY

Any fertility issues? **Yes** **No** If yes, please explain:

Did mother smoke? **Yes** **No** If yes, please explain:

Did mother drink? **Yes** **No** If yes, please explain:

Did mother exercise? **Yes** **No** If yes, please explain:

Was mother ill? **Yes** **No** If yes, please explain:

Any Ultrasounds? **Yes** **No** If yes, please explain:

Please recall any episodes of mental or physical stress during pregnancy:

Please note any other concerns you would like us to be aware of about conception or pregnancy:

LABOR AND DELIVERY

Child's birth was: (circle one) **Natural vaginal birth** **Scheduled C-section** **Emergency C-section**

Delivery interventions and complications include: (circle all that apply)
Breech **Induction** **Pain medication** **Epidural** **Episiotomy** **Vacuum extraction** **Forceps** **Other:**

Please note any other concerns or notable remarks about labor and/or delivery:

DEVELOPMENT HISTORY

Is/was your child breastfed? **Yes** **No** If yes, for how long?

Has he/she ever had formula? **Yes** **No** If yes, at what age?

Did/does your child ever suffer from colic, reflux, or constipation as an infant?
Yes **No** If yes, please explain:

Did/does your child arch their neck or back and/or feel stiff?
Yes **No** If yes, please explain:

At what age did your child:
Respond to sound: _______ Follow an object: ______ Hold their head up: ______ Vocalize: ______ Teethe: ______
Sit alone: ______ Crawl: ______ Begin cow's milk: ______ Begin solid foods: ______

Any known food intolerances or allergies? If yes, please explain:

Please list your child's hospitalization and surgical history:

Please note any injuries, accidents, falls, and/or fractures your child has sustained:

Have you chosen to vaccinate your child? (circle) **No** **Yes, on a delayed schedule** **Yes, on schedule**
Please list any reactions, if any, to any of the vaccinations:

Has your child received any antibiotics? **Yes** **No**
How many times? And for what reason?

Difficulty sleeping? **Yes** **No** If yes, explain:

Behavior, social, or emotional issues or concerns? **Yes** **No** If yes, explain:

How many hours a day does your child spend watching TV, computer, tablet, or phone?

How would you describe your child's diet? **Organic** **Average** **High amounts of processed foods**

CONSENT

PATIENT SIGNATURE: ______________________________________ DATE: ____________________