Pediatric Patient Questionnaire

1. CONFIDENTIAL PATIENT INFORMATION:

Child's First Name: ______________________ Child's Last Name ______________________

Date of Birth: __________ Gender: __________ Street Address: __________ Apt./Unit #: __________

City: __________ State: ______ Zip Code: __________ Cell Phone: __________

Home Phone: ______________ Work Phone: ______________

Email: ______________________ Height: __________ Weight: __________

Parent/Guardian Name(s): ______________________ Emergency Contact (Name & Phone Number) ______________________

Who is your child's primary care physician? ____

2. Who Is responsible for this bill?

First Name: __________ Last Name: __________ Date of Birth: __________ SSN: __________

Marital Status:
○ Single ○ Married ○ Domestic Partner ○ Separated ○ Divorced ○ Widowed

Spouses name: __________

Street Address __________ Apt./Unit #: __________ City: __________ State: __________ Zip Code: __________

Mobile Phone: ______________ Email: ______________

I hereby authorize payment to be made directly to STATERA CHIROPRACTIC, for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application, or copies thereof, for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to STATERA CHIROPRACTIC for any and all services I receive at this office. Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/former spouse or other guardian is not required. If my authority to so select and authorize this care should change in any way, I will immediately notify this office.

____ Signature

__________________ Date

3. **How did you hear about us? (please select all that apply & list who in the box that appears)**

- ☐ Current Patient (list who) ____________
- ☐ Professional Referral/Doctor (list who) ____________
- ☐ Google Search ____________
- ☐ Facebook/Instagram ____________
- ☐ Community Partner (list who) ____________
- ☐ Other (specify) ____________

4. **Is your child receiving care from any other health professionals? If yes, please name them and their specialty:**

	Name	Specialty
1		
2		
3		

Others:

____

5. **Is your child taking any drugs, medications, vitamins, herbs, etc.?**

	Medication Name	Dosage	Frequency	Reason for Taking
1				
2				
3				

Others:

____

CURRENT HEALTH CONDITIONS

6. What are the primary health concerns for your child?

7. Please describe when your child's health concerns first began and how they have progressed since:

8. What improves your child's health concerns?

9. What makes your child's health concerns worse?

HEALTH GOALS FOR YOUR CHILD

10. What are your top three health goals for your child:

    1.

    2.

    3.

11. What would you like to gain from chiropractic care?

    ○ Resolve existing condition ○ Overall wellness + prevention ○ Both

12. Have you or your child ever visited a chiropractor?

    ○ Yes ○ No

    If yes, what is their name:

13. If yes, what is their specialty?

- ○ Pain Relief
- ○ Physical Therapy & Rehab
- ○ Nutritional
- ○ Subluxation-based
- ○ Other

If other, specify:

____

PREGNANCY & FERTILITY HISTORY

Please tell us about your pregnancy.

14. Have you or your spouse experienced fertility challenges?

- ○ Yes
- ○ No

If yes, please explain:

____

15. Please select any that applied during the mother's pregnancy:

- ☐ Consumed alcohol
- ☐ Consumed nicotine
- ☐ Used non-prescription drugs
- ☐ Major Illnesses
- ☐ Surgeries
- ☐ None

If yes, please clarify:

____

16. Did the mother exercise during her pregnancy?

- ○ Yes
- ○ No

17. Did the mother receive any ultrasounds?

- ○ Yes
- ○ No

18. Please explain any notable episodes of emotional or physical stress during your pregnancy:

____

____

____

____

19. Please explain any other concerns or notable remarks about your child's conception or pregnancy:

____

____

____

____

LABOR & DELIVERY HISTORY

20. At how many week's was your child born?

____

Child's birth was:
- ○ Vaginal Birth
- ○ Scheduled C-section
- ○ Emergency C-section

21. Child's birth weight: ______________________

Child's birth height: ______________________

APGAR score at birth: ______________________

APGAR score at 5 minutes: ______________________

22. **Child's birth was:**

- ○ At home
- ○ At a birthing center
- ○ At a hospital
- ○ Other

If other, specify:

____

23. Birth Provider's Name(s):

____

24. **Please check any applicable interventions or complications:**

- ☐ Breech
- ☐ Induction
- ☐ Pain meds
- ☐ Manual assistance
- ☐ Epidural
- ☐ Episiotomy
- ☐ Vacuum extraction
- ☐ Forceps
- ☐ Cord-wrapped
- ☐ None of the above

If other, specify:

____

25. **Please describe any other concerns or notable remarks about your child's labor and/or delivery.**

____

____

____

____

GROWTH & DEVELOPMENT HISTORY

26. **Is/was your child breastfed?**

- ○ Yes
- ○ No

If yes, how long?

____

27. **Difficulty with breastfeeding?**

- ○ Yes
- ○ No

If yes, is there a certain side that is more difficult for them?

____

28. Did they ever use formula?

○ Yes ○ No

If yes, at what age?

____

29. At what age did the child (put "X" if the child has not yet met the milestone):

	Age
Respond to sound:	
Follow an object:	
Hold their head up:	
Vocalize:	
Teething:	
Sit alone:	
Crawl:	
Walk:	
Begin cow’s milk:	
Begin solid foods:	

30. Please list any food intolerance or allergies, and when they began:

	Food intolerance / Allergy	When they began
1		
2		
3		

31. Please list your child's hospitalization and surgical history, including the year:

	Hospitalization / Surgery	Year
1		
2		
3		

32. Please list any major injuries, accidents, falls and/or fractures your child has sustained in his/her lifetime, including the year:

	Injury	Year
1		
2		
3		

33. Has your child received any vaccinations?

○ Yes, on schedule ○ Yes, on a delayed or selective schedule ○ No

If yes, were there any adverse reactions or complications?

____

34. Has your child received any antibiotics? If yes, please complete the chart below for each antibiotic administered.

Number of Antibiotics	Reason for Antibiotic	When (Date)	Age

Further explanation if necessary

____

35. Does your child have any difficulty with bonding or social development?

○ Yes ○ No

If yes, please explain:

____

36. Does your child have night terrors or difficulty sleeping?

○ Yes ○ No

If yes, please explain:

____

37. Does your child have any behavioral, social or emotional issues?

○ Yes ○ No

If yes, please explain:

____

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

____

39. How would you describe your child's diet?

- ○ Mostly whole, organic foods
- ○ Pretty average
- ○ High amount of processed foods

Patient Review of Systems

The nervous system controls and coordinates all organs and structures of the human body.

Please check the corresponding boxes for each symptom or condition your child has experienced - including both past and present.

40.

	Past	Present
Colic & Excessive Crying		
Difficulty Latching / Nursing		
Reflux & Excessive Spit Up		
Projectile Vomiting		
Frequent Stiffening, Rigidity, Arching		
Difficulty Sleeping		
Torticollis		
Plagiocephaly		
Motor Milestone Delays		
Low Tone & Coordination Challenges		
Speech & Communication Delays		
Sensory Processing Challenges		
Social / Emotional Challenges		
Frequent Tantrums & Meltdowns		
Behavior Issues		
Hyperactivity & Impulsivity		
Anxiety & Emotional Instability		
ADHD / ADD		
Balance & Coordination Issues		
Visual & Auditory Processing Challenges		
Handwriting & Fine Motor Challenges		
Low Energy and Fatigue		
Depression & Lack of Confidence		
Lightheadedness & Dizziness		
Frequent Naseau & Malaise		

Headaches & Migraines		
Stick Neck & Shoulders		
Jaw, Swallowing, Sensory Food Aversions		
Vision & Hearing Issues		
Ear & Sinus Infections		
Sore Throat and Strep		
Swollen Tonsiles & Adenoids		
Strep & Upper Respiratory Infections		
Allergies and Autoimmune Challenges		
Chronic Inflammation		
Poor Metabolism & Weight Control		
Chronic Chest Colds & Cough		
Bronchitis & Pneumonia		
Asthma		
Blood Sugar Problems		
Skin Conditions / Rash		
Ulcerative Colitis, Crohn’s, IBS		
Kidney Challenges		
Gas Pain & Bloating		
Gluten & Casein Intolerance		
Constipation		
Bladder & Urination Issues		
Hormonal Challenges		
Low Back Pain & Stiffness		
Lumbopelvic / SI Joint Pain		
Tight Hamstrings & Calves		
Toe Walking		
Poor Circulation & Cold Feet		
Weak Ankles & Arches		
None of the Above		

41. Are there any other health concerns, or anything else you'd like us to know about your child?

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ACKNOWLEDGEMENT & CONSENT

I understand that I am directly and fully responsible to Statera Chiropractic for all fees associated with chiropractic care my child receives.

The risks associated with exposure to ionization and spinal adjustments have been explained to me to my complete satisfaction, and I have conveyed my understanding of these risks to the doctor. After careful consideration I do hereby request and authorize imaging studies and chiropractic adjustments for the benefit of my minor child for whom I have the legal right to select and authorize health care services on behalf of.

JDD, DC 5/2011

□ Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/former spouse or other guardian is not required. If my authority to so select and authorize this care should change in any way, I will immediately notify this office.

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______________________________________ ________________________

Signature Date