Pediatric Patient Questionnaire

Big Beautiful Life
Chiropractic & Wellness

CONFIDENTIAL PATIENT INFORMATION

Child's Name	Parent/Guardian Name(s):		
Street Address:	City, State, Zip:		
Cell Phone:	Other Phone:	Child's Sex: ◯ M ◯ F	
Email:		Birthdate:	Age:
How did you hear about us?		Weight:	Height:

Who is your primary care physician?

Is your child receiving care from any other health professionals? ◯ Yes ◯ No
If yes, please name them and their specialty:

Please list any drugs/medications/vitamins/herbs/other that your child is taking:

CURRENT HEALTH CONDITIONS

What health condition(s) bring your child to be evaluated by a chiropractor?

When did the condition first begin? ◯ Suddenly ◯ Gradually ◯ Post-Injury
How did the problem start?

Has your child ever received care for this condition before? ◯ Yes ◯ No
If yes, please explain:

Is this condition: ◯ Getting Worse ◯ Improving ◯ Intermittent ◯ Constant ◯ Unsure

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

HEALTH GOALS FOR YOUR CHILD

What are your top three health goals for your child?

1. _____
2. _____
3. _____

What would you like to gain from chiropractic care for your child?

◯ Resolve existing condition ◯ Overall wellness ◯ Both

Has your child ever seen a chiropractor? ◯ Yes ◯ No If yes, what is their name and how long did they see them?

What is their specialty? ◯ Pain Relief ◯ Physical Therapy & Rehab ◯ Nutritional
◯ Subluxation-based ◯ Other _____

PREGNANCY & FERTILITY HISTORY

Please tell us about your child's gestation

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

Did mother smoke? ◯ Yes ◯ No If yes, how many per week?

Did mother drink? ◯ Yes ◯ No If yes, how many per week?

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 explain any notable episodes of mental or physical stress during your child's gestation:

Please explain any other concerns or notable remarks about your child's conception or gestation:

LABOR & DELIVERY HISTORY

Child's birth was: ◯ Natural vaginal birth ◯ Scheduled C-section ◯ Emergency C-section
At how many week's was your child born?

Child's birth was: ◯ At home ◯ At a birthing center ◯ At a hospital ◯ Other _____
Doctor/Obstetrician's Name:

Please check any applicable interventions or complications: ◯ Other _____
◯ Breech ◯ Induction ◯ Pain meds ◯ Epidural ◯ Episiotomy ◯ Vacuum extraction ◯ Forceps

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

Child's birth weight: Child's birth height: APGAR score at birth: APGAR score after 5 minutes:

GROWTH & DEVELOPMENT HISTORY

Is/was your child breastfed? ◯ Yes ◯ No *If yes, how long?* Difficulty with breastfeeding? ◯ Yes ◯ No

Did they ever use formula? ◯ Yes ◯ No *If yes, at what age?* *If yes, what type?*

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

Did/does your child frequently arch their neck/back, feel stiff or bang their head? ◯ 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:* _____ *Walk:* _____ *Begin cow's milk:* _____ *Begin solid foods:* _____

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

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

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GROWTH & DEVELOPMENT HISTORY (CONTINUED)

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

Have you chosen to vaccinate your child? ◯ Yes, on a delayed/selective schedule ◯ Yes, on schedule ◯ No
If yes, please list any vaccination reactions:

Has your child received any antibiotics? ◯ Yes ◯ No
If yes, how many times and list reason:

Night terrors or difficulty sleeping? ◯ Yes ◯ No *If yes, please explain:*

Behavioral, social or emotional issues? ◯ Yes ◯ No *If yes, please explain:*

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

How would you describe your child's diet? ◯ Mostly whole, organic foods ◯ Pretty average ◯ High amount of processed foods

ACKNOWLEDGMENT & CONSENT

I, _____, being the parent or legal guardian of _____ grant permission
(Parent/ Guardian Name) (Child's Name)
for my child to receive a chiropractic assessment and chiropractic care. Date: _____