PEDIATRIC QUESTIONNAIRE

Name: (Last, First MI)_____ **Today's Date:** _____

PEDIATRIC REVIEW OF SYSTEMS

Pediatric:

- ☐ ADHD
- ☐ Allergies/Asthma
- ☐ Autism
- ☐ Back/Neck Pain
- ☐ Bed Wetting
- ☐ Behavioral issues
- ☐ Chronic Earaches
- ☐ Colic
- ☐ Constipation
- ☐ Growing Pains
- ☐ Nightmares
- ☐ Reflux
- ☐ *None in this Category*

Childhood Diseases:

- ☐ Chicken Pox: Age ____
- ☐ Measles: Age ____
- ☐ Meningitis: Age ____
- ☐ Mumps: Age ____
- ☐ Rubella: Age ____
- ☐ Tuberculosis: Age ____
- ☐ Whooping Cough: Age ____
- ☐ Other:_____ Age ____
- ☐ *None in this Category*

Has your child been vaccinated?

☐ **No** ☐ **Yes**

*(Any Adverse Reactions? – Describe:)*_____

_____

INFANTS AND NEWBORNS

Prenatal History:

Location of Birth: ☐ Home ☐ Birthing Center ☐ Hospital

Birth Weight: _____ **Birth Length:** _____ **Full Term?** ☐ **No** ☐ **Yes** *(Describe)*_____

Complications during pregnancy? ☐ **No** ☐ **Yes** *(Describe)*_____

Medications during pregnancy or delivery? ☐ **No** ☐ **Yes** *(List)*_____

Cigarette / Alcohol / Drugs during pregnancy? ☐ **No** ☐ **Yes** *(List)*_____

Birth Interventions? ☐ **No** ☐ **Yes** ☐ Forceps ☐ Vacuum ☐ Caesarian ☐ Other: _____

Complications during delivery? ☐ **No** ☐ **Yes** *(Describe)*_____

Feeding History:

Breast fed? ☐ **No** ☐ **Yes** *(How Long?)*_____ **Formula fed?** ☐ **No** ☐ **Yes** *(How Long?)*_____ *(Type?)*_____

Introduced to cereal at ____ months old. **Solids at____ months old.** **Cow's milk at____ months old.**

Food / Juice allergies or intolerances? ☐ **No** ☐ **Yes** *(Describe)*_____

Developmental History:

Sleep *(Hours per Night?)*_____ **Problems Sleeping?** *(Describe)*_____

CONSENT FOR TREATMENT OF A MINOR

I hereby authorize: _____ *(Doctor's Name)* and whomever he or she may designate as assistants to administer examinations and chiropractic care as deemed necessary to: _____ *(Minor Patient's Name)*

_____
Printed Name of Parent or Guardian

_____ _____
Signature of Parent or Guardian Date

_____ _____
Witness Date

Patient No: _____

PEDIATRIC HISTORY FORM

PATIENT DEMOGRAPHICS

HR#:_____

Today's Date _____/_____/____

Childs Name_____

Date of Birth _____/_____/_____ Age: _____

Birth Height: _____ Birth Weight: _____ Current Height: _____ Current Weight: _____

Address _____

City _____ State _____ Zip _____ Phone (Home) _____

Mother's Name: _____ DOB____/____/____ Mother's Mobile _____

Father's Name: _____ DOB ____/____/____ Father's Mobile _____

Pediatrician/Family MD _____City/State _____

Last Visit: ____/____/____ Reason for visit:_____

Who is responsible for this bill? _____

☐ Father's Social Security #_____-_____-_____ ☐ Mother's Social Security #_____-_____-_____

☐ Other *(please explain)*: _____

CHILD'S CURRENT PROBLEM:

Purpose of this visit: _____Wellness Check-up _____Injury or Accident _____Other

Please explain: _____

*If your child is experiencing **Pain/Discomfort please identify where and for how long***

_____

_____

1. **When did the** Problem first begin? Date ___/___/___ __Unknown __Gradual __Sudden
2. **Ever had** this problem **before**? ___ No ___Yes If yes, when? _____
3. Any **bowel or bladder** problems since this problem began?: If yes, describe:

_____

4. Have you seen any **other doctors** for this problem? ___No ___Yes If yes, who?

_____

5. How long ago? _____Days _____Weeks _____Months _____Years
6. What were the results of past treatment? _____
7. How is this problem **NOW?:** ☐ Rapidly Improving ☐ Improving Slowly ☐ About the Same

☐ Gradually Worsening ☐ On & Off

8. Please list any **medication taken** for this problem: _____

9. Has your child ever sustained an injury playing organized sports? ___ No ___ Yes If yes; please explain:

_____

_____

_____

10. Has your child ever sustained an injury in an auto accident? ___ No ___ Yes If yes; please explain:

_____

_____

_____

HAS YOUR CHILD EVER SUFFERED FROM: *Check all that apply*

☐ Headaches	☐ Orthopedic Problems	☐ Digestive Disorders	☐ Behavioral Problems
☐ Dizziness	☐ Neck Problems	☐ Poor Appetite	☐ ADD/ADHD
☐ Fainting	☐ Arm Problems	☐ Stomach Aches	☐ Ruptures/Hernia
☐ Seizures/Convulsions	☐ Leg Problems	☐ Reflux	☐ Muscle Pain
☐ Heart Trouble	☐ Joint Problems	☐ Constipation	☐ Growing Pains
☐ Chronic Earaches	☐ Backaches	☐ Diarrhea	☐ Asthma
☐ Sinus Trouble	☐ Poor Posture	☐ Hypertension	☐ Walking Trouble
☐ Scoliosis	☐ Anemia	☐ Colds/Flu	☐ Sleeping Problems
☐ Bed Wetting	☐ Colic	☐ Broken Bones	☐ Fall off swing
☐ Fall in baby walker	☐ Fall from bed or couch	☐ Fall from crib	☐ Fall down stairs
☐ Fall off bicycle	☐ Fall from high chair	☐ Fall off slide	
☐ Fall from changing table	☐ Fall off monkey bars	☐ Fall off skateboard/skates	

☐ Allergies to_____

☐ Other: _____

I understand that I am directly and fully responsible to Cates Chiropractic Clinic, LLC 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.

☐ 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.

_____ _____

Parent or Legal Guardian's Signature Date

_____ _____

Doctor's Signature Date