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: _____