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: _____