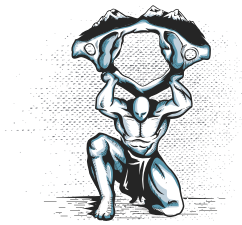

UPPER CERVICAL CHIROPRACTIC OF BEMIDJI

PEDIATRIC PATIENT *Questionnaire* 0–8 YEARS

Today's date: _____ Referred by: _____

CONFIDENTIAL PATIENT INFORMATION

Child's First Name: _____ Last Name: _____ DOB: ___ / ___ / _____

Preferred Name: _____ Preferred Pronoun: ◯ She ◯ He ◯ _____ Gender: _____

Parent 1 Name: _____ DOB: ___ / ___ / _____ Cell Phone: _____

Parent 2 Name: _____ DOB: ___ / ___ / _____ Cell Phone: _____

Street Address: _____ City: _____ State: _____ ZIP: _____

Email: _____ Phone: _____ How did you hear about us? _____

Would you like appointment reminders: ◯ Text message ◯ Email ◯ No Phone carrier: _____

Who is your child's primary care provider? _____ Last visit date: _____

Is your child receiving care from any other professional? ◯ Yes ◯ No

- If yes, please name them and their specialty: _____

Has your child ever been to a chiropractor? ◯ Yes ◯ No

- If yes, chiropractor's name _____ Last visit date: _____

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

Please indicate any medications (prescription and non-prescription) your child is currently taking:

◯ Painkillers ◯ Muscle Relaxers ◯ Insulin ◯ Antacids ◯ Antibiotics ◯ Allergy meds ◯ Asthma meds/inhaler ◯ ADHD meds

◯ Depression/anxiety meds ◯ Other medications: _____

CURRENT HEALTH

What health concern brings your child into our office? _____

Have they received care for this concern before? ◯ Yes ◯ No

- If yes, please explain: _____

When did the concern(s) first begin? _____

How did the concern start? ◯ Suddenly ◯ Gradually ◯ Post-Injury

Is this concern: ◯ Getting worse ◯ Improving ◯ Intermittent ◯ Constant ◯ I'm not sure

What makes the concern better? _____

What makes the concern worse? _____

What are your expectations? _____

HEALTH GOALS

What are your top three health goals for your child:

_____

_____

_____

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

◯ Resolve existing condition

◯ Overall wellness

◯ Both

PREGNANCY & FERTILITY HISTORY

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 pregnancy:

_____

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

_____

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: _____

Midwife's/Obstetrician's Name: _____

Third Trimester Presentation: ◯ Vertex (head down) ◯ Posterior ◯ Breech ◯ Transverse ◯ Face/brow ◯ Other: _____

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

◯ Other: _____

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

_____

Child's birth weight: ____ lbs. ____ oz. Child's birth height: ____ in. 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? _____ What type? _____

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

- If yes, please explain: _____

Has your child ever been diagnosed with any of the following?: ◯ Tongue tie ◯ Lip tie ◯ Failure to thrive ◯ Latching issues

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 the 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: _____

_____

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? ◯ No ◯ Yes, on a delayed or selective schedule ◯ Yes, on schedule

- If yes, please list any vaccination reactions: _____

Has your child received any antibiotics? ◯ Yes ◯ No

- If yes, how many times and list reason: _____

Does your child have night terrors or difficulty sleeping? ◯ Yes ◯ No

- If yes, please explain: _____

Does your child have behavioral, social or emotional issues? ◯ Yes ◯ No

- If yes, please explain: _____

Does your child have any sensory processing or neurodevelopmental disorders? ◯ 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

WHAT CAUSES *subluxations?*

To help the doctor understand your child's situation better, what are some of the things in their life that may be causing stress in their body and therefore subluxation in their spine on an ongoing basis?

Trauma
PHYSICAL STRESS

- ☐ Accidents and falls
- ☐ Birth
- ☐ Extended time in car seats, bouncers or rockers, jolly jumpers, bumbo seats, etc.
- ☐ Latching issues
- ☐ _____

Toxins
CHEMICAL STRESS

- ☐ Poor diet (high sugar, GMOs, artificial foods)
- ☐ Medications, antibiotics, vaccines
- ☐ Environmental toxins (air pollution, cleaning supplies, smoke, tap water, mold, etc.)
- ☐ Soaps, lotions, diaper creams, etc.
- ☐ _____

Thoughts
EMOTIONAL STRESS

- ☐ Fear and anxiety
- ☐ Not enough sleep
- ☐ Screen time
- ☐ Social challenges (divorce, death in the family, stressed parent, not enough family time, etc.)
- ☐ _____

Please explain: _____

_____

Parent/Guardian Signature: _____ Print: _____ Date: _____