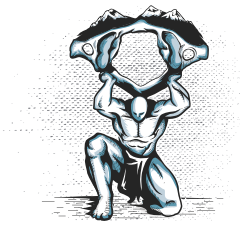

UPPER CERVICAL CHIROPRACTIC OF BEMIDJI

PEDIATRIC PATIENT *Questionnaire* 13–17 YEARS

Today's date: _____ Referred by: _____

CONFIDENTIAL PATIENT INFORMATION

Legal 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 primary care provider? _____ Last visit date: _____

Are you receiving care from any other professional? ◯ Yes ◯ No

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

Have you 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) you are currently taking:

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

◯ Depression/anxiety meds ◯ Other medications: _____

HEALTH GOALS

What are your top three health goals:

_____

_____

_____

What would you like to gain from chiropractic care?

◯ Resolve existing condition

◯ Overall wellness

◯ Both

CURRENT HEALTH

What health concern brings you into our office? _____

Have you 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? _____

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

_____

Please list your hospitalization and surgical history, including the year: _____

_____

Please list any major injuries, accidents, falls and/or fractures you have sustained in your lifetime, including the year:

_____

Have you been vaccinated? ◯ No ◯ Yes, on a delayed or selective schedule ◯ Yes, on schedule

- If yes, please list any vaccination reactions: _____

Have you received any antibiotics? ◯ Yes ◯ No

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

Do you have night terrors or difficulty sleeping? ◯ Yes ◯ No

- If yes, please explain: _____

How many hours per day do you typically spend watching a TV, computer, tablet or phone? _____

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

Are you involved in sports? ◯ Yes ◯ No

- If yes, list sports and any associated injuries: _____

_____

FOR FEMALES ONLY

Has menstruation started? ◯ Yes ◯ No If yes, date of first period: _____

Severe cramping or painful period? ◯ Yes ◯ No

Length in days: _____ Flow: ◯ Heavy ◯ Medium ◯ Light

Birth Control (if applicable, what type): _____

WHAT CAUSES *subluxations?*

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

Trauma PHYSICAL STRESS	*Toxins* CHEMICAL STRESS	*Thoughts* EMOTIONAL STRESS
☐ Accidents and falls	☐ Poor diet (high sugar, GMOs, artificial additives)	☐ Fear and anxiety
☐ Bad habits (e.g. crossing legs, sleeping on the stomach, sitting all day, frequent texting, wearing bag or backpack only on one side)	☐ Medications, antibiotics, vaccines	☐ Busy lifestyle, not enough sleep
☐ Sport injuries	☐ Environmental toxins (air pollution, cleaning supplies, smoke/vape, perfumes, etc.)	☐ Technology overload
		☐ Social challenges (bullying, stress at school, exams, etc.)
☐ _____	☐ _____	☐ _____

Please explain: _____

_____

_____

Patient Signature: _____ Print: _____ Date: _____

LABOR & DELIVERY HISTORY

✲ ✲ ✲ TO BE FILLED OUT BY PARENT OR GUARDIAN ✲ ✲ ✲

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: _____

Midife'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: ____

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