



UPPER CERVICAL
CHIROPRACTIC
OF BEMIDJI

PEDIATRIC PATIENT
Questionnaire
9-12 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: _____

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 pregnancy:

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: _____

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? _____

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

Is your child involved in sports? Yes No

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

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 subluxation in their spine on an ongoing basis?

Trauma PHYSICAL STRESS

- Accidents and falls
- Birth
- Bad habits (crossing legs, sleeping on the stomach, sitting all day, frequent texting, etc.)
- Sport injuries
- _____

Toxins CHEMICAL STRESS

- Poor diet (high sugar, GMOs, artificial additives)
- Medications, antibiotics, vaccines
- Environmental toxins (air pollution, cleaning supplies, tap water, etc.)
- _____

Thoughts EMOTIONAL STRESS

- Fear and anxiety
- Busy lifestyle
- Technology overload
- Social challenges (bullying, stress at school, exams, etc.)
- _____

Please explain: _____

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): _____

Parent/Guardian Signature: _____ Name: _____ Date: _____