



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:  Email  No Email address for reminders: \_\_\_\_\_

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:

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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:

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

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# 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:

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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: \_\_\_\_\_