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: ◯ 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: ______________

## 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: ____________________

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: _____

# 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: ____________