

Pediatric Patient Questionnaire

Confidential Patient Information

Child's Name:	Parent / Guardian Name(s):		
Street Address:	City, State, Postal Code:		
Cell Phone:	Other Phone:	Child's Sex:	
Email:	Child's SSN:	Birthdate:	Age:
How did you hear about us?		Height:	Weight:
Who is your primary care physician?			
Is your child receiving care from any other health professionals? ☐ Yes ☐ No – If yes, please name them and their specialty:			
Please list any drugs/medications/vitamins/herbs or other that your child is taking:			

Current Health Conditions

What health condition(s) bring your child to be evaluated by a chiropractor?			
When did the condition first begin?	How did the problem start?	☐ Suddenly	☐ Gradually ☐ Post-Injury
Has your child ever received care for this condition? ☐ Yes ☐ No – If yes, please explain:			
Is this condition: ☐ Getting worse ☐ Improving ☐ Intermittent ☐ Constant ☐ Unsure			
What makes the problem better?		What makes the problem worse?	

Health Goals for Your Child

What are your top three health goals for your child?	What would you like to gain?
1. _____	☐ Resolve existing condition
2. _____	☐ Overall wellness
3. _____	☐ Both
Has your child ever visited a chiropractor? ☐ Yes ☐ No – If yes, what is their name:	
– What is their specialty: ☐ Pain Relief ☐ Physical Therapy & Rehab ☐ Nutrition ☐ Subluxation-based ☐ Other:	

Pregnancy & Fertility History

Please tell us about your pregnancy:		
Any fertility issues?	☐ Yes ☐ No	If yes, please explain: _____
Did mother smoke?	☐ Yes ☐ No	If yes, how often? _____
Did mother drink?	☐ Yes ☐ No	If yes, how often? _____
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 noticable 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 weeks was your child born?

Where was your child born? _____ – Who delivered your baby? _____

Please indicate any applicable interventions or complications:

☐ Breech ☐ 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: _____ Child's birth height: _____ APGAR score at birth: _____ APGAR score after 5 min.: _____

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? _____ – If yes, what type? _____

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

– If yes, please explain: _____

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 vaccine reactions: _____

Has your child received any antibiotics? ☐ Yes ☐ No

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

Night terrors or difficulty sleeping? ☐ Yes ☐ No – If yes, please explain: _____

Behavioral, social or emotional issues? ☐ Yes ☐ No – If yes, please explain: _____

How many hours per day does your child typically spend watching TV, computer, tablet or phone? _____

How would you describe your child's diet? ☐ Mostly whole, organic foods ☐ Pretty average ☐ High amount of processed foods

Acknowledgement & Consent

Parent/Guardian Signature: _____

Date: _____

Flack Family Chiropractic

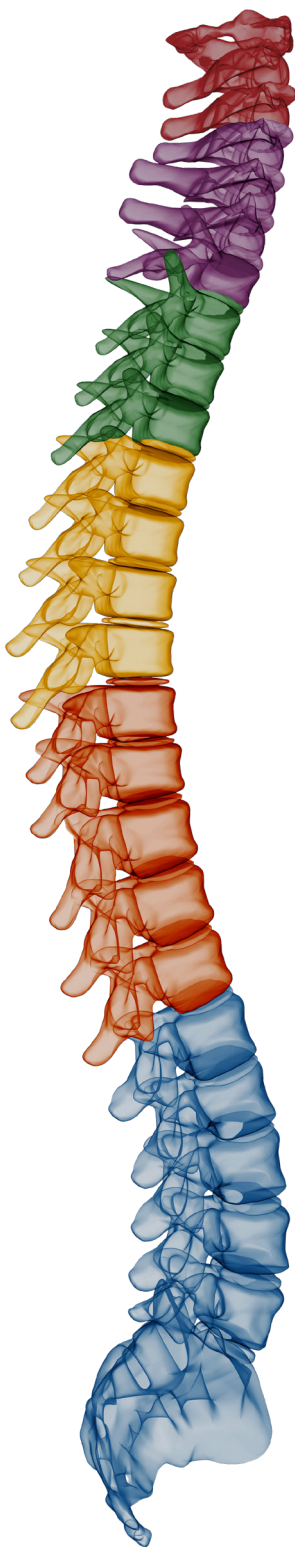
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Patient Review of Systems

THE NERVOUS SYSTEM CONTROLS AND COORDINATES ALL ORGANS AND STRUCTURES OF THE HUMAN BODY

Please check the corresponding boxes for each symptom or condition you have experienced – including both past and present.



REGIONS	FUNCTIONS	SYMPTOMS					
		PAST	PRESENT	PAST	PRESENT		
Cervical	• Autonomic Nervous System	☐	☐	Colic & Excessive Crying	☐	☐	Epilepsy & Seizures
	• ENT System	☐	☐	Ear & Sinus Infections	☐	☐	Sensory & Spectrum
	• Vision, Balance & Coordination	☐	☐	Allergies & Congestion	☐	☐	ADD / ADHD
	• Speech	☐	☐	Immune Deficiency	☐	☐	Focus & Memory Issues
	• Immune System	☐	☐	Headaches & Migraines	☐	☐	Anxiety & Stress
	• Digestive System	☐	☐	Vertigo & Dizziness	☐	☐	Balance & Coordination
	• Nerve Supply to Shoulders, Arms & Hands	☐	☐	Sore Throat & Strep	☐	☐	Speech Issues
	• Sympathetic Nucleus	☐	☐	Swollen Tonsils & Adenoids	☐	☐	TMJ / Jaw Pain
	• Metabolism	☐	☐	Vision & Hearing Issues	☐	☐	Stiff Neck & Shoulders
			☐	☐	Low Energy & Fatigue	☐	☐
		☐	☐	Difficulty Sleeping	☐	☐	High Blood Pressure
		☐	☐	Pain, Numbness & Tingling in Arms to Hands	☐	☐	Poor Metabolism & Weight Control
Upper Thoracic	• Upper G.I.	☐	☐	Reflux / GERD	☐	☐	Bronchitis & Pneumonia
	• Respiratory System	☐	☐	Chronic Colds & Cough	☐	☐	Functional Heart Conditions
	• Cardiac Function	☐	☐	Asthma			
Mid Thoracic	• Major Digestive Center	☐	☐	Gallbladder Pain / Issues	☐	☐	Indigestion & Heartburn
	• Detox & Immunity	☐	☐	Jaundice	☐	☐	Stomach Pains & Ulcers
		☐	☐	Fever	☐	☐	Blood Sugar Problems
Lower Thoracic	• Stress Response	☐	☐	Behavior Issues	☐	☐	Allergies & Eczema
	• Filtration & Elimination	☐	☐	Hyperactivity	☐	☐	Skin Conditions / Rash
	• Gut & Digestion	☐	☐	Chronic Fatigue	☐	☐	Kidney Problems
	• Hormonal Control	☐	☐	Chronic Stress	☐	☐	Gas Pain & Bloating
Lumbar, Sacrum & Pelvis	• Lower G.I. (Absorption & Motility)	☐	☐	Constipation	☐	☐	Sciatica & Radiating Pain
	• Gut-Immune System	☐	☐	Chrohn's, Colitis & IBS	☐	☐	Lumbopelvic / SI Joint Pain
	• Major Hormonal Control	☐	☐	Diarrhea	☐	☐	Hamstring Tightness
		☐	☐	Bed-wetting	☐	☐	Disc Degeneration
		☐	☐	Bladder & Urination Issues	☐	☐	Leg Weakness & Cramps
		☐	☐	Cramps & Menstrual Issues	☐	☐	Poor Circulation & Cold Feet
		☐	☐	Cysts & Endometriosis	☐	☐	Knee, Ankle & Foot Pain
		☐	☐	Infertility	☐	☐	Weak Ankles & Arches
		☐	☐	Impotency	☐	☐	Lower Back Pain
		☐	☐	Hemorrhoids	☐	☐	Gluten & Casein Intolerance

Patient Name: _____ Date: _____