Pediatric Questionnaire

(Ages 5 and below)

Name: _____ DOB: _____ Today's Date: _____

Specific Symptoms/Concerns

What are the symptoms? List all that apply with the most severe listed first.

1. _____
2. _____
3. _____
4. _____
5. _____

How did the symptoms occur? _____

When did the symptoms begin? _____

Are the symptoms constant, do they come and go or does it fluctuate? _____

Have the symptoms been getting better, worse or staying the same? _____

Are there any bumps/scrapes or cuts from the incident? _____

Have you done anything to alleviate the symptoms? _____

Have eating habits changed due to the symptoms? _____

Have bathroom habits changed due to the symptoms? _____

Have sleeping habits changed due to the symptoms? _____

Have sleeping positions changed due to the symptoms? _____

Any fevers of unknown origins since start of symptoms? _____

Any mood changes since start of symptoms? _____

Office use only: Height _____ Weight_____ Pulse_____ Respiratory_____ Blood Pressure ____/____

Birth

Was the child's birth on time, early or late? _____

Was the child's delivery vaginal or cesarean? _____

Length of labor? _____

Born at home or in a hospital? _____

Were extracting aids used? _____

APGAR score at birth _____/10 and 5 minutes after birth _____/10

Was there more than one fetus during the pregnancy? _____

Did the mother use alcohol or smoke during pregnancy? _____

Is the child vaccinated? If so, were there any adverse reactions? _____

Has the child been reaching developmental milestones? _____

Pediatric Past Medical History

Has the child had previous similar symptoms? (mark what applies)

_____ 0 times previously _____1-3 times previously _____4+ times previously

Does the child have any concurrent conditions? (circle what applies)

Frequent colds, frequent falls, colic, bed-wetting, crying spells, asthma, ADD/ADHD, growing pains, refusal to eat, back pain, headaches, allergies, food allergies, tonsil problems, skin rash spina bifida, seizures, ear infections, stomach pains, autism

Has the child been treated by a Chiropractor before? _____

Has the child been to a Medical Doctor for this condition? _____

Has the child had any past illnesses or injuries? Mark n/a or yes. If yes, please describe in the space provided below.

☐ N/A ☐ Yes, see list

Date	Illness/injury
_____	_____
_____	_____
_____	_____

Pediatric Family History

List any current or past health conditions of the child's family members. (If deceased, at what age and from what)

Father: _____

Mother: _____

Sister(s): _____

Brother(s): _____

Pediatric Systems Review

Has the child had any problems with the following areas now or in the past? (Mark yes or no and circle the conditions that apply)

___ Eyes (glasses, contacts, pink eye, glaucoma, macular degeneration, cataracts)

___Ears, Mouth, Nose, Throat (ear infection, hearing loss, sinus infections, nasal polyps)

___Cardiovascular (heart murmur, irregular heartbeat, hypertension, heart disease, high cholesterol)

___Respiratory (lung disease, difficulty breathing, asthma, bronchitis, COPD, emphysema, pneumonia)

___Neurological (weakness, numbness)

___ Endocrine (thyroid disease, hormonal imbalance, liver disease, kidney disease, diabetes)

___Gastro-Intestinal (acid reflux, colic, constipation, I.B.S, crohns disease, stomach ulcers, intestinal ulcers)

___Genito-Urinary (bed wetting, kidney stones, UTI)

___Musculoskeletal (fractures, dislocations, spondylolisthesis, sprain/strain, arthritis)

___Skin (rashes, dryness, psoriasis, hair loss, eczema)

___Psychiatric (anxiety, depression, bipolar, ADD/ADHD)

___Illness (fever, chills, nausea, chest pain, dizziness, headache)

Allergies

Mark n/a or yes. If yes, please list allergies in the space provided below.

☐ N/A ☐ Yes, see list

_____

_____

_____

Current Prescription Medications

Mark n/a or yes. If yes, please list meds in the space provided below.

☐ N/A ☐ Yes, see list

Name of Prescription	Dose (mg, mL)	Form	Duration
_____	_____	_____	____x per ____
_____	_____	_____	____x per ____
_____	_____	_____	____x per ____