Murdock Family Chiropractic

Pediatric Patient Questionnaire

CONFIDENTIAL PATIENT INFORMATION

Child's Name:		Parent/Guardian Name(s):	
Street Address:		City, State, Zip:	
Cell Phone:	Home Phone:	Work Phone:	
Email:	Child's SS#:	Birthdate:	Age:
How did you hear about us?		Weight:	Height:

Who is your primary care physician?

Is your child receiving care from any other health professionals? O Yes O No
-If yes, please name them and their specialty:

Please list any drug/medications/vitamins/herbs/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? O Suddenly O Gradually O Post-Injury

Has your child ever received care for this condition before? O Yes O No
-If yes, please explain:

Is this condition: O Getting worse O Improving O Intermittent O Constant O Unsure

What makes the problem better?

What makes the problem worse?

YOUR HELATH GOALS

What are your top three health goals for your child:	What would you like to gain from chiropractic care?
1. _____	O Resolve existing condition
2. _____	O Overall wellness
3. _____	O Both

Have you ever visited a chiropractor? O Yes O No If yes, what is their name?
What is their specialty?
O Pain relief O Physical Therapy & Rehab O Nutrition O Subluxation-based O Other: _____

PREGNANCY & FERTILITY HISTORY

Please tell us about your pregnancy

Any fertility issues?	O Yes O No	If yes, please explain:
Did mother smoke?	O Yes O No	If yes, how many per week?
Did mother drink?	O Yes O No	If yes, how many per week?
Did mother exercise?	O Yes O No	If yes, please explain:
Was mother ill?	O Yes O No	If yes, please explain:
Any ultrasounds?	O Yes O No	If yes, please explain:

Please explain any notable episodes of mental or physical stress during pregnancy:

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

LABOR AND DELIVERY HISTORY

Child's birth was: ○ Natural vaginal birth ○ Scheduled C-section ○ Emergency C-section How many weeks at time of birth?

Child's birth was: ○ At home ○ At a birthing center ○ At a hospital ○ Other: _____ Doctor/Obstetrician's name:

Please check 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 minutes:

GROWTH & DEVELOPMENT

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, what age? If yes, what type?

Did/does your child ever 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 year:

Please list any major injuries, accidents, falls and/or fractures your child has sustained in his/her lifetime, including 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:

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

Patient Signature: _____ Date: _____

murdock family
CHIROPRACTIC