



PEDIATRIC HEALTH QUESTIONNAIRE

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Please take a moment to answer the following questions that are designed to maximize your child's health. Many types of stresses (physical, mental, chemical) can interfere with your child's growing spine and nervous system. Spinal health is an exciting new concept for many people, so please remember to ask questions.



Child's Name: _____ Age: _____ Date of birth _____
Parent's Name: _____

Reason for visit to our office: _____

Circle Appropriately:

Birth Place: Home Hospital Birth Center

Delivered by: Mid Wife OB/GYN

Type of Birth: Vaginal C-section

Procedures: Forceps Vacuum Extraction Epidural

Delivery Complications: _____

Ultrasound during pregnancy? Yes No If yes, how many? _____

Is/Was your child breast fed? Yes No If yes, how long: _____

Intolerance or allergy to formula or foods? Yes No If yes, what: _____

Does your child take vitamins or supplements? Yes No

Did your child reach developmental milestones such as crawling, walking, and talking at appropriate ages? Yes No

According to the National Safety Council, approximately 50% of infants fall head first from a high place (bed, couch, changing table) during the first year of life.

Has this happened to your child? Yes No

Has your child been involved in a motor vehicle accident of any kind? Yes No

Has your child had surgery? Yes No If yes, for what? _____

Has your child been seen by either a doctor or hospital on an emergency basis? _____

Does your child have any learning challenges? Yes No If yes, what are they? _____

Which sports does your child participate in: Soccer Football Gymnastics Dance
Karate Hockey Baseball Basketball Other: _____

Does your child carry a backpack? Yes No

Circle/Check any of the following your child has had in the past 12 months:

Ear infection	Scoliosis	Seizures	Chronic cold
Asthma	Allergies	ADD	ADHD
Colic	Psoriasis	Diabetes	Headaches
Bed wetting	Back discomfort	Growing Pains	Digestive Problems
Recurring fevers	Temper Tantrums	Visual Impairment	Hearing difficulty
Eczema	Mood swings		

Approximately how many prescriptions of antibiotics has your child taken?

During the past 12 months: _____ During his/her lifetime: _____

Approximately how many other prescription medications has your child taken?

During the past 12 months: _____ During his/her lifetime: _____

Reason for prescriptions: _____

How many over the counter medications has your child taken? (Ex: Tylenol, Ibuprofen)

During the past 12 months: _____ During his/her lifetime: _____

Types: _____

Is your child currently taking **any** medications? Yes No

If yes, what: _____

Vaccinations: After careful consideration of the literature and facts, some parents choose not to have their child vaccinated.

Has your child been vaccinated? Yes No

If yes, what age was their first vaccine? _____

If you vaccinate, are they current? Yes No

Has your child ever had a reaction of **any** kind to a vaccination? Yes No

If yes, what type of reaction (fever, rash, sleeplessness): _____

Are you interested and committed to safeguarding your child's health? Yes No

I authorize the doctors at Stucky Chiropractic Center to examine and care for my child.

Signed: _____ Date: _____

(Parent or Guardian)