PEDIATRIC HEALTH QUESTIONARE

2105 E Clairemont Avenue, Eau Claire, WI 54701 (715) 835-9514, Fax (715) 835-2602

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 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)