PEDIATRIC HEALTH QUESTIONARE

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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: ☐Forcepts ☐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)