

# PEDIATRIC QUESTIONNAIRE

Name: (Last, First MI) \_\_\_\_\_

Today's Date: \_\_\_\_\_



## PEDIATRIC REVIEW OF SYSTEMS

### Pediatric:

- ADHD
- Allergies/Asthma
- Autism
- Back/Neck Pain
- Bed Wetting
- Behavioral issues
- Chronic Earaches
- Colic
- Constipation
- Growing Pains
- Nightmares
- Reflux
- None in this Category

### Childhood Diseases:

- Chicken Pox: Age \_\_\_\_\_
- Measles: Age \_\_\_\_\_
- Meningitis: Age \_\_\_\_\_
- Mumps: Age \_\_\_\_\_
- Rubella: Age \_\_\_\_\_
- Tuberculosis: Age \_\_\_\_\_
- Whooping Cough: Age \_\_\_\_\_
- Other: \_\_\_\_\_ Age \_\_\_\_\_
- None in this Category

### Has your child been vaccinated?

- No  Yes

(Any Adverse Reactions? - Describe:) \_\_\_\_\_



## INFANTS AND NEWBORNS

### Prenatal History:

Location of Birth:  Home  Birthing Center  Hospital

Birth Weight: \_\_\_\_\_ Birth Length: \_\_\_\_\_ Full Term?  No  Yes (Describe) \_\_\_\_\_

Complications during pregnancy?  No  Yes (Describe) \_\_\_\_\_

Medications during pregnancy or delivery?  No  Yes (List) \_\_\_\_\_

Cigarette / Alcohol / Drugs during pregnancy?  No  Yes (List) \_\_\_\_\_

Birth Interventions?  No  Yes  Forceps  Vacuum  Caesarian  Other: \_\_\_\_\_

Complications during delivery?  No  Yes (Describe) \_\_\_\_\_

### Feeding History:

Breast fed?  No  Yes (How Long?) \_\_\_\_\_ Formula fed?  No  Yes (How Long?) \_\_\_\_\_ (Type?) \_\_\_\_\_

Introduced to cereal at \_\_\_\_\_ months old. Solids at \_\_\_\_\_ months old. Cow's milk at \_\_\_\_\_ months old.

Food / Juice allergies or intolerances?  No  Yes (Describe) \_\_\_\_\_

### Developmental History:

Sleep (Hours per Night?) \_\_\_\_\_ Problems Sleeping? (Describe) \_\_\_\_\_

## CONSENT FOR TREATMENT OF A MINOR

I hereby authorize: \_\_\_\_\_ (Doctor's Name) and whomever he or she may designate as assistants to administer examinations and chiropractic care as deemed necessary to: \_\_\_\_\_ (Minor Patient's Name)

\_\_\_\_\_  
Printed Name of Parent or Guardian

\_\_\_\_\_  
Signature of Parent or Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

Patient No: \_\_\_\_\_