PRAIRIE CHIROPRACTIC
PEDIATRIC QUESTIONNAIRE

(10 YEARS AND UNDER) (PLEASE PRINT)

Date_____ **DOB** _____

Full LEGAL Name _____
First Middle Last

Mother's Name _____ Father's Name _____

Phone _____ Phone _____

Email _____ Email _____

How did you find our office? _____

HISTORY OF PRESENTING ILLNESS/INJURY (LIST IN ORDER OF IMPORTANCE)

Child's symptoms 1) _____

Date symptom began _____ **Auto Related?** ☐ No ☐ Yes

How did it occur? _____

2) _____

Date symptom began _____ **Auto Related?** ☐ No ☐ Yes

How did it occur? _____

3) _____

Date symptom began _____ **Auto Related?** ☐ No ☐ Yes

How did it occur? _____

Recent X-rays of the area(s)? ☐ No ☐ Yes Facility where taken? _____

Has child received previous Chiropractic care? ☐ No ☐ Yes

HISTORY OF PRESENT ILLNESS - CHIEF COMPLAINT(S)

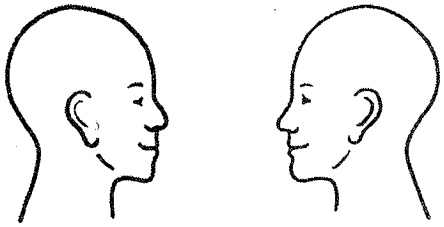
(see also page 1)

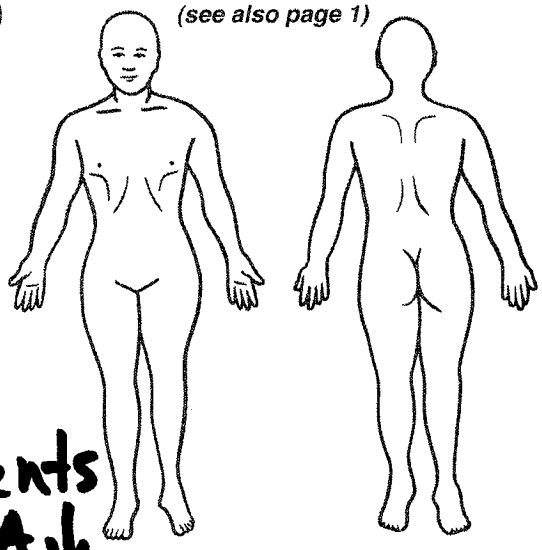
Fill out this section as accurately as possible. Mark the area with the described sensation using the appropriate symbols from the left. Rate your pain on the scale below from 0 to 100 (0 = no pain; 100 = intolerable pain). If there is more than one area of discomfort, please rate the pain 0 to 100 next to each area as appropriate.

__ Constant
__ Comes/Goes

__ Getting Better
__ Getting Worse
__ Staying Same

Better:	Worse:
___ AM	___
___ MID-DAY	___
___ PM	___





ONLY FOR Patients UNDER 5 YOA

NO PAIN **PAIN SCALE:** **INTOLERABLE**

0___5___10___15___20___25___30___35___40___45___50___55___60___65___70___75___80___85___90___95___100

What have you tried so far to remedy the problem(s):_____

Was child's delivery: ☐ On Time ☐ Early ☐ Late

Explain: _____

Was the child's delivery: ☐ Vaginal ☐ Cesarean (c-section)

How long was labor: _____

Was the child born: ☐ at home ☐ in hospital

Name of Midwife/Doctor: _____

What was your child's APGAR score _____/10 at birth _____/10 five minutes after birth

Were extraction aids (forceps/suction) used? No Yes
If YES, explain_____

Was there more than one fetus? No Yes
If YES, explain_____

Did the mother use any alcohol or smoke during pregnancy? No Yes
If YES, how much & how often _____

Is/Was your child vaccinated? No Yes
If YES, describe any adverse reactions _____

Is/Was your child breastfed? No Yes
If YES, describe any difficulties_____

Does child have preferred side or head position for sleeping, riding in car seat, breastfeeding? No Yes
If YES, describe _____

Did/Does your child use formula? No Yes
If YES, describe any difficulties/allergies _____

Is your child meeting their developmental milestones? No Yes
If NO, explain _____

Any recent loss of appetite or change in eating habits No Yes
If YES, describe _____

Any recent change in bathroom habits? No Yes
If YES, describe _____

Any change in sleeping habits? No Yes
If YES, describe _____

Does child have preferred sleeping position in bed? No Yes
If YES, describe _____

Any bumps/scrapes/cuts? No Yes
If YES, describe _____

Any recent fevers of unknown origins? No Yes
If YES, describe _____

PAST MEDICAL HISTORY *(see also page 1)*

How often has child had this condition in the past? ☐ Never ☐ 1-3 Times ☐ 4 or More Times

Has child seen a Medical Doctor for this Condition? ☐ No ☐ Yes – Doctor/Clinic _____

Does child have any other Health Conditions? (Check all that apply):

☐ Diabetes ☐ Asthma ☐ IBS/Colitis ☐ Cancer

☐ Other: _____

Describe any major Illnesses, Injuries, Falls, Hospitalizations, Accidents or Surgeries:

DATE	DOCTOR	CONDITION(S)	RESULTS
_____	_____	_____	☐ Full Recovery ☐ Complications
_____	_____	_____	☐ Full Recovery ☐ Complications
_____	_____	_____	☐ Full Recovery ☐ Complications
_____	_____	_____	☐ Full Recovery ☐ Complications
_____	_____	_____	☐ Full Recovery ☐ Complications
_____	_____	_____	☐ Full Recovery ☐ Complications

SOCIAL HEALTH HISTORY

Recreational Activities/Hobbies _____

Does child consume Caffeine? ☐ No ☐ Yes – How Much? _____ How Often? _____

FAMILY HEALTH HISTORY

List any current or past health conditions of family members (if deceased, indicate at what age and from what?)

MOTHER: _____

FATHER: _____

BROTHERS: _____ How Many _____

SISTERS: _____ How Many _____

SYSTEM REVIEW QUESTIONS

Does child have problems with the following areas Now or in the Past? (Y = Yes and **N** = No)

___**Eyes** (Glasses, Etc)

___**Ears** (Ear Infections, Hearing, Etc)

___**Mouth, Nose, Throat** (Sinuses, Etc)

___**Cardiovascular** (Heart, Etc)

___**Respiratory** (Lungs, Breathing, Asthma, Etc)

___**Neurological** (Nerve Issues, Weakness, Numbness, Etc)

___**Endocrine** (Thyroid, Imbalances, Liver, Etc)

___**Gastro-Intestinal** (Colic, Acid Reflux, Etc)

___**Genito-Urinary** (Male/Female Reproductive, Kidney, Bladder, Etc)

___**Musculoskeletal** (Breaks, Etc)

___**Skin** (Rashes, Dryness, Psoriasis, Eczema, Hair, Etc)

___**Psychiatric** (Anxiety, Depression, ADD/ADHD, Etc)

___**Others:** _____

Please describe in more detail: _____

NOTES