# 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? ____________________________________________

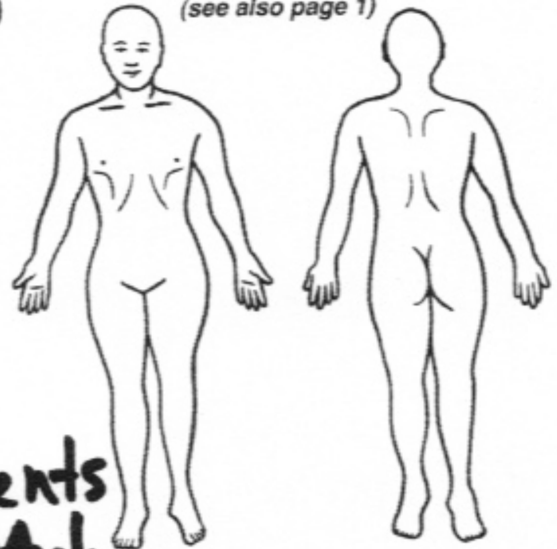
**Recent X-rays of the area(s)?** ☐ No ☐ Yes Facility where taken? ______________________________

**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

| | No | Yes |
|---|---|---|
| Were extraction aids (forceps/suction) used?<br>If YES, explain ____________________ | No | Yes |
| Was there more than one fetus?<br>If YES, explain ____________________ | No | Yes |
| Did the mother use any alcohol or smoke during pregnancy?<br>If YES, how much & how often ____________________ | No | Yes |
| Is/Was your child vaccinated?<br>If YES, describe any adverse reactions ____________________ | No | Yes |
| Is/Was your child breastfed?<br>If YES, describe any difficulties ____________________ | No | Yes |
| Does child have preferred side or head position for sleeping, riding in car seat, breastfeeding?<br>If YES, describe ____________________ | No | Yes |
| Did/Does your child use formula?<br>If YES, describe any difficulties/allergies ____________________ | No | Yes |
| Is your child meeting their developmental milestones?<br>If NO, explain ____________________ | No | Yes |
| Any recent loss of appetite or change in eating habits<br>If YES, describe ____________________ | No | Yes |
| Any recent change in bathroom habits?<br>If YES, describe ____________________ | No | Yes |
| Any change in sleeping habits?<br>If YES, describe ____________________ | No | Yes |
| Does child have preferred sleeping position in bed?<br>If YES, describe ____________________ | No | Yes |
| Any bumps/scrapes/cuts?<br>If YES, describe ____________________ | No | Yes |
| Any recent fevers of unknown origins?<br>If YES, describe ____________________ | No | Yes |

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## 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**

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