FAMILY CHIROPRACTIC & Wellness

Reclaim your health.

2629 University Blvd.,
Ames, IA 50010
Phone: (515) 233-9087
Fax: (515) 233-6409

Pediatric Intake Questionnaire

CONFIDENTIAL PATIENT INFORMATION

First Name:	Last Name:	Date:
SSN:	DOB:	Sex:
Height:	Weight:	Age:
Parent/Guardian Name(s):		Phone #:
Street Address:	City, State, Postal Code:	
How did you hear about us?	Who is your primary care physician?	

Is your child receiving care from any other health professionals? ◯Yes ◯No
If yes, please name them and their specialty:

Please list any drugs, medications, vitamins, herbs, or others that that your child is taking:

CURRENT HEALTH CONDITIONS

What health condition(s) bring your child to be evaluated by a chiropractor?

When did the condition first begin? How did the problem start? ◯Suddenly ◯Gradually ◯Post-Injury

Has your child ever received care for this condition? ◯Yes ◯No
If yes, please explain:

Is this condition: ◯Getting worse ◯Improving ◯Intermittent ◯Constant ◯Unsure

What makes the problem better? What makes the problem worse?

HEALTH GOALS FOR YOUR CHILD

What are your top three health goals for your child?

1. ______________________________
2. ______________________________
3. ______________________________

What would you like to gain?

◯Resolve existing condition
◯Overall wellness
◯Both

Has your child ever visited a chiropractor? ◯Yes ◯No If yes, what is their name?

PREGNANCY & FERTILITY HISTORY

Please tell us about your pregnancy:

Any fertility issues?	◯Yes ◯No	If yes, please explain: ______________
Did mother smoke?	◯Yes ◯No	If yes, how often?______________
Did mother drink?	◯Yes ◯No	If yes, how often?______________
Did mother exercise?	◯Yes ◯No	If yes, please explain: ______________
Was mother ill?	◯Yes ◯No	If yes, please explain: ______________
Any ultrasounds?	◯Yes ◯No	If yes, please explain: ______________

Please explain any other concerns or notable remarks about your child’s conception or pregnancy:

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LABOR & DELIVERY HISTORY

Child's birth was: ◯Natural vaginal birth ◯Scheduled C-section ◯Emergency C-section

At how many weeks was your child born?

Where was your child born? Who delivered your baby?

Please indicate any applicable interventions or complications:
◯Breach ◯Induction ◯Pain meds ◯Epidural ◯Episiotomy ◯Vacuum extraction ◯Forceps
◯Other:

Please describe any other concerns or notable remarks about your child's labor and/or delivery:

Birth weight: Birth height: APGAR score at birth: APGAR score after 5 minutes:

GROWTH & DEVELOPMENT HISTORY

Is/was your child breastfed? ◯Yes ◯No If yes, how long? Any difficulty? ◯Yes ◯No

Did they ever use formula? ◯Yes ◯No If yes, at what age? If yes, what type?

Did/does your child suffer from colic, reflux, or constipation as an infant? ◯Yes ◯No
If yes, please explain:

Did/does your child frequently arch their neck/back, feel stiff, or bang their head? ◯Yes ◯No
If yes, please explain:

At what age did the child: Respond to sound: _____ Follow an object: _____ Hold their head up: _____
Vocalize: _____ Sit alone: _____ Crawl: _____ Walk: _____ Begin cow's milk: _____ Begin solid foods: _____

Please list any food intolerance or allergies, and when they began:

Please list your child's hospitalization and surgical history (including the year):

Please list any major injuries, accidents, falls, and fractures your child has sustained in his/her life (including the year):

Have you chosen to vaccinate your child? ◯No ◯Yes, on a delayed or selective schedule ◯Yes, on schedule
If yes, please list any vaccine reactions:

Has your child received any antibiotics? ◯Yes ◯No
If yes, how many times and list reason:

Night terrors or difficulty sleeping? ◯Yes ◯No If yes, please explain:

Behavioral, social, or emotional issues? ◯Yes ◯No If yes, please explain:

How many hours per day does your child typically spend watching TV, computer, tablet, or phone?

How would you describe your child's diet? ◯Mostly whole, organic foods ◯Average ◯Lots of processed foods

Acknowledgment & Consent

Signature: ______________________________ Date: ______________