Pediatric Patient Questionnaire

Confidential Patient Information

Child's Name: | Parent/Guardian Name(s):

Street Address: | City, State, Postal Code:

Cell Phone: | Other Phone: | Child's Sex:

Email: | Birthdate: | Age:

How did you hear about us? | Height: | Weight:

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 other 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:

– What is their specialty: ☐ Pain Relief ☐ Physical Therapy & Rehab ☐ Nutrition ☐ Subluxation-based ☐ Other:

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 noticable episodes of mental or physical stress during your pregnancy:

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

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:
☐ Breech ☐ 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:

Child's birth weight: Child's birth height: APGAR score at birth: APGAR score after 5 min.:

Growth & Development History

Is/was your child breastfed? ☐ Yes ☐ No – If yes, how long? Difficulty with breastfeeding? ☐ 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:
Teethe: 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/or fractures your child has sustained in his/her lifetime (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 ☐ Pretty average ☐ High amount of processed foods

Acknowledgement & Consent

Parent/Guardian Signature: Date:

Authorization and Release

I understand that I am responsible for all costs of chiropractic care. Segura Family Chiropractic is a cash-based practice and does not bill insurance. I authorize the doctor to release information necessary to communicate with my child's other healthcare providers. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

Thepatient understands and agrees to allow this chiropractic office to use their PatientHealth Information for the purposeoftreatment, payment and healthcare operations, and coordination of care. We wantyou to know how your patientHealthInformation is going to be used in this office and your rights concerning thoserecords. If you would like to have amoredetailed account of our policies and procedures concerning the privacy of yourPatient Health Information encourageyoutoread the HIPAA NOTICE that is available to you at the front desk beforesigning this consent.

The following person(s) have my permission to receive my personal health information:

Name Relationship

Icertify the information provided is accurate to the best of my knowledge:

Signature of Patient: Date:

Guardian's Signature Authorizing Release: Date:

Informed Consent

The Doctor will use their hands or a mechanical instrumentupon your body in such a way as to move your joints. This procedure is referred to as "Spinal Manipulation" or "Spinal Adjustment." As the joints in your spine are moved, you may experience a "pop" as part of the process.

There are certain complications that can occur as a result of spinal manipulation. These complications include, but are not limited to: muscle strain, cervical myelopathy, disc and vertebral injury, fractures, strains and dislocations, Bernard-Horner's Syndrome, (also known as Oculosympathetic Palsy), costovertebral strains and separation. Rare complications include, but are not limited to stroke. The most common complication or complain following spinal manipulation is an ache or stiffness at the site of adjustment.

I am aware of these complications, and in order to minimize their occurrence I will take precautions. These precautions include, but are not limited to, taking a detailed clinical history of you and examining you for any defect which could cause a complication. This examination may include the use of x-rays. The use of x-ray equipment may pose a risk if you are pregnant.

IF YOU ARE PREGNANT, OR THINK YOU MAY BE PREGNANT YOU SHOULD TELL ME OR MY OFFICE STAFF AT THE TIME OF YOUR EXAM.

Printed Patient Name: Date:

Patient Signature:

Signature of Parent or Guardian (if minor):