Today's Date: _____

Name: (Last, First, MI) _____ Birth Date: _____

Address:_____ City:_____ State:_____
Zip:_____ Phone:_____ Parent/Legal Guardian Names: _____

PEDIATRIC QUESTIONNAIRE

Pediatric:

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

INFANTS AND NEWBORNS

Prenatal History:
Location of Birth: • Home • Birthing Center • Hospital. **Full Term? _____**

Please list other Chief Complaint here:

_____

_____

_____

Full Term? Formula fed? • No • Yes *(How Long?)* _____ *(Type?)* _____ **Solids at____ months old.**
Cow's milk at____ months old.

Birth Weight: _____ Birth Length: _____
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?)* _____ **Introduced to cereal 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

*Who may we thank for referring you? _____