Optimal Health Chiropractic

PEDIATRIC HEALTH QUESTIONNAIRE Date_____
(To be completed by Parent or Legal Guardian)

Age (yrs.)_____(mos.)____ Date of Birth_____ Gender: M F # of Siblings_____

Birth Weight_____ Birth Length_____

Present Weight_____ Present Length/Heigth_____

Was the birth: ❑ Normal ❑ Forceps ❑Vacuum extraction
❑Cesarean ❑Breech ❑ Home birth
❑Birthing Center ❑ Hospital APGAR Scores

Pregnancy problems_____

Labor or Delivery Problems_____

Congenital Defects/ Anomalies_____

Was there presence at birth: ❑ Meconium ❑Cyanosis (blue) ❑ Jaundice (yellow)

Pediatrician/Family MD_____ Address_____

Obstetrician/ Midwife_____ Address_____

Immunization Dates: DTP_____ MMR_____ VAR_____
Polio_____ HEP B_____ TB_____
Small pox_____ Haemophilus influenza_____

Childhood diseases: ❑Chickenpox ❑Whooping cough ❑Measles
❑Rubella (German Measles) ❑Roseola infantum(pseudorubella)
❑ Croup (acute laryngotracheobronchitis) ❑Mumps

Date and purpose of last MD visit_____

Has this child been treated for any emergency? Yes NO Describe_____
_____

Surgeries_____

Medications_____

Accidents_____

Check (✓) all that apply

❑Allergies	❑Cold/Flu	❑Hear Trouble	❑Poor appetite	❑Headaches
❑Anemia	❑Constipation	❑Hyperactivity	❑Rheumatic fever	
❑Arm Problems	❑Convulsion	❑Hypertension	❑Ruptures/Hernias	
❑Arthritis	❑Diabetes	❑ Joint problems	❑Sinus trouble	
❑Asthma	❑Diarrhea	❑Leg problems	❑Sugar level	
❑Backaches	❑Dizziness	❑Muscle Jerking	❑Tuberculosis	
❑Bed Wetting	❑Paralysis	❑Neck Problems	❑Walking Problems	
❑Behavior Problems	❑Fainting	❑Neuritis	❑Broken bones	
❑"Growing pains"	❑Orthopedic Problems	❑Digestion Problems	❑Chronic Earaches	

Is there anything else we should know about this child?_____

Diet_____

Environmental Factors_____

PERSONAL INJURY ONLY:

Was your child injured in automobile accident? Yes NO
If YES, please explain_____
_____

Was the child riding in a car seat? YES NO_____

Was the car seat in the front or rear seat, facing forward or backward?_____

Was the child struck by an air bag? YES NO _____

Was the child in a booster seat? YES NO _____

Was the vehicle struck from the Rear / Front / Left Side / Right Side?

List any visible bumps, bruises, cuts, etc on the child that were caused by this accident?

I CERTIFY THAT THE INFORMATION ON THIS FORM IS TRUE TO THE BEST OF MY KNOWLEDGE.

PRINT Patient Name_____

Signature of Parent or Legal Guardian_____Date_____