RCW School Age New Patient Paperwork

Pediatric Patient Questionnaire

1. CONFIDENTIAL PATIENT INFORMATION:

Child's Name: _____ Date of Birth: _____ Gender: _____

Street Address: _____ Apt./Unit #: _____ Parent/Guardian Name(s): _____

City: _____ State: _____ Zip Code: _____ Cell Phone: _____

Home Phone: _____ Work Phone: _____

Email: _____ Height: _____ Weight: _____

Who is your primary care physician?

_____

2. How did you hear about us? (please select all that apply & list who in the box that appears)

☐ Current Patient (list who) _____

☐ Professional Referral/Doctor (list who) _____

☐ Google Search _____

☐ Social Media (list platform) _____

☐ Community Partner (list who) _____

☐ Other (specify) _____

3. Is your child receiving care from any other health professionals?

○ Yes ○ No

4. If yes, please name them and their specialty:

	Name	Specialty
1		
2		
3		

Others: _____

5. Please list any drugs/medications/vitamins/herbs/other that your child is taking:

	Medication Name	Dosage	Frequency	Reason for Taking
1				
2				
3				

Others:

_____

CURRENT HEALTH CONDITIONS

6. What are the primary health concerns for your child?

_____

_____

_____

_____

7. Please describe when your child's issues first began and how they've progressed since:

_____

_____

_____

_____

8. What makes things better?

_____

_____

_____

_____

9. What makes things worse?

_____

10. Check any of the following that are affected:

- ☐ School
- ☐ Playing
- ☐ Communication
- ☐ Behavior
- ☐ Exercise/sports
- ☐ Sleep
- ☐ Eating
- ☐ Walking
- ☐ Attention Focus
- ☐ Daily Routine

HEALTH GOALS FOR YOUR CHILD

11. What are your top three goals for your child:

1. _____

2. _____

3. _____

12. What would you like to gain from chiropractic care?

- ○ Resolve existing condition
- ○ Overall wellness + prevention
- ○ Both

13. Have you ever visited a chiropractor?

- ○ Yes
- ○ No

If yes, what is their name:

_____

14. What is their specialty?

- ○ Pain Relief
- ○ Physical Therapy & Rehab
- ○ Nutritional
- ○ Subluxation-based
- ○ Other

If other, specify:

_____

PREGNANCY & FERTILITY HISTORY

Please tell us about your pregnancy.

15. Any fertility challenges?

- ○ Yes
- ○ No

If yes, please explain:

_____

16. Did mother smoke?

- ○ Yes
- ○ No

If yes, how many per week?

_____

17. Did mother drink?

○ Yes ○ No

If yes, how many per week?

_____

18. Did mother exercise?

○ Yes ○ No

If yes, please explain:

_____

19. Was mother ill?

○ Yes ○ No

If yes, please explain:

_____

20. Any ultrasounds?

○ Yes ○ No

If yes, please explain:

_____

21. Please explain any notable episodes of emotional or physical stress during your pregnancy:

_____

_____

_____

_____

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

_____

_____

_____

_____

LABOR & DELIVERY HISTORY

23. Child's birth was:

○ Vaginal Birth ○ Scheduled C-section ○ Emergency C-section

At how many week's was your child born?

_____

24. Child's birth was:

- ○ At home
- ○ At a birthing center
- ○ At a hospital
- ○ Other

If other, specify:

_____

25. Birth Provider's Name or Location:

_____

26. Please check any applicable interventions or complications:

- ☐ Breech
- ☐ Induction
- ☐ Pain meds
- ☐ Manual assistance
- ☐ Epidural
- ☐ Episiotomy
- ☐ Vacuum extraction
- ☐ Forceps
- ☐ Cord-wrapped
- ☐ None of the above

If other, specify:

_____

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

_____

_____

_____

_____

28. Child's birth weight: _____ Child's birth height: _____ APGAR score at birth: _____ APGAR score at 5 minutes: _____

GROWTH & DEVELOPMENT HISTORY

29. Is/was your child breastfed?

- ○ Yes
- ○ No

If yes, how long?

_____

30. Difficulty with breastfeeding?

- ○ Yes
- ○ No

If yes, is there a certain side that is more difficult for them?

_____

31. Did they ever use formula?

- ○ Yes
- ○ No

32. If yes:

At what age:

_____

33. Did/does your child ever suffer from colic, reflux, skin issues, or constipation as an infant?

○ Yes ○ No

If yes, please explain:

_____

34. Did/does your child frequently arch their neck/back, feel stiff, or bang their head?

○ Yes ○ No

If yes, please explain:

_____

35. At what age did the child:

	Age
Respond to sound:	
Follow an object:	
Hold their head up:	
Vocalize:	
Teething:	
Sit alone:	
Crawl:	
Walk:	
Begin cow's milk:	
Begin solid foods:	

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

	Food intolerance / Allergy	When they began
1		
2		
3		

37. Please list your child's hospitalization and surgical history, including the year:

	Hospitalization / Surgery	Year
1		
2		
3		

38. Please list any major injuries, accidents, falls and/or fractures your child has sustained in his/her lifetime, including the year:

	Injury	Year
1		
2		
3		

39. Have you chosen to vaccinate your child?

- ○ No
- ○ Yes, on a delayed or selective schedule
- ○ Yes, on schedule

If yes, any vaccine reactions?

_____

40. Has your child received any antibiotics?

- ○ Yes
- ○ No

41. If yes, please complete the chart below for each antibiotic administered.

Number of Antibiotics	Reason for Antibiotic	When (Date)	Age

42. Any difficulty with bonding or social development?

- ○ Yes
- ○ No

If yes, please explain:

_____

43. Night terrors or difficulty sleeping?

- ○ Yes
- ○ No

If yes, please explain:

_____

44. Behavioral, social or emotional issues?

○ Yes ○ No

If yes, please explain:

_____

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

_____

46. How would you describe your child's diet?

○ Mostly whole, organic foods ○ Pretty average ○ High amount of processed foods

47. Does your child play a sport? If yes, which one(s):

_____

Emotional Stress

48. It is difficult to separate the emotional stress in our life from the physical response that often occurs. Please indicate if your child has ever or is currently experiencing any of the emotional stresses below:

☐ Academic pressure ☐ Loss of a loved one ☐ Bullying
☐ Relocation ☐ Lifestyle change ☐ Parents' divorce
☐ Loss of a pet ☐ New sibling

49. Does your child have difficulty interacting with schoolmates or friends?

_____

50. Have your or anyone else noticed that your child is nervous, twitches, shakes, or exhibits rocking behavior?

_____

51. Are there other health concerns, or is there anything else you'd like us to know about your child?

_____

_____

_____

_____

Patient Review of Systems

The nervous system controls and coordinates all organs and structures of the human body.

Please check the corresponding boxes for each symptom or condition you have experienced - including both past and present.

52.

	Past	Present
Colic & Excessive Crying		
Difficulty Latching / Nursing		
Reflux & Excessive Spit Up		
Projectile Vomiting		
Frequent Stiffening, Rigidity, Arching		
Difficulty Sleeping		
Torticollis		
Plagiocephaly		
Motor Milestone Delays		
Low Tone & Coordination Challenges		
Speech & Communication Delays		
Sensory Processing Challenges		
Social / Emotional Challenges		
Frequent Tantrums & Meltdowns		
Behavior Issues		
Hyperactivity & Impulsivity		
Anxiety & Emotional Instability		
ADHD / ADD		
Balance & Coordination Issues		
Visual & Auditory Processing Challenges		
Handwriting & Fine Motor Challenges		
Low Energy and Fatigue		
Depression & Lack of Confidence		
Lightheadedness & Dizziness		
Frequent Naseau & Malaise		
Headaches & Migraines		
Stick Neck & Shoulders		
Jaw, Swallowing, Sensory Food Aversions		

Vision & Hearing Issues		
Ear & Sinus Infections		
Sore Throat and Strep		
Swollen Tonsiles & Adenoids		
Strep & Upper Respiratory Infections		
Allergies and Autoimmune Challenges		
Chronic Inflammation		
Poor Metabolism & Weight Control		
Chronic Chest Colds & Cough		
Bronchitis & Pneumonia		
Asthma		
Blood Sugar Problems		
Skin Conditions / Rash		
Ulcerative Colitis, Crohn's, IBS		
Kidney Challenges		
Gas Pain & Bloating		
Gluten & Casein Intolerance		
Constipation		
Bladder & Urination Issues		
Hormonal Challenges		
Low Back Pain & Stiffness		
Lumbopelvic / SI Joint Pain		
Tight Hamstrings & Calves		
Toe Walking		
Poor Circulation & Cold Feet		
Weak Ankles & Arches		

ACKNOWLEDGEMENT & CONSENT

Patient or Parent/Guardian

_____ _____

Signature Date