RCW Pediatric 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?

_____

HEALTH GOALS FOR YOUR CHILD

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

1. _____

2. _____

3. _____

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

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

12. Have you ever visited a chiropractor?

- ○ Yes
- ○ No

If yes, what is their name:

_____

13. 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.

14. Any fertility challenges?

- ○ Yes
- ○ No

If yes, please explain:

_____

15. Did mother smoke?

- ○ Yes
- ○ No

If yes, how many per week?

_____

16. Did mother drink?

○ Yes ○ No

If yes, how many per week?

_____

17. Did mother exercise?

○ Yes ○ No

If yes, please explain:

_____

18. Was mother ill?

○ Yes ○ No

If yes, please explain:

_____

19. Any ultrasounds?

○ Yes ○ No

If yes, please explain:

_____

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

_____

_____

_____

_____

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

_____

_____

_____

_____

LABOR & DELIVERY HISTORY

22. Child's birth was:

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

At how many week's was your child born?

_____

23. Child's birth was:

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

If other, specify:

_____

24. Birth Provider's Name or Location:

_____

25. 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:

_____

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

_____

_____

_____

_____

27. Child's birth weight: _____

Child's birth height: _____

APGAR score at birth: _____

APGAR score at 5 minutes: _____

GROWTH & DEVELOPMENT HISTORY

28. Is/was your child breastfed?

- ○ Yes
- ○ No

If yes, how long?

_____

29. Difficulty with breastfeeding?

- ○ Yes
- ○ No

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

_____

30. Did they ever use formula?

- ○ Yes
- ○ No

31. If yes:

At what age:

_____

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

○ Yes ○ No

If yes, please explain:

_____

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

○ Yes ○ No

If yes, please explain:

_____

34. 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:	

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

	Food intolerance / Allergy	When they began
1		
2		
3		

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

	Hospitalization / Surgery	Year
1		
2		
3		

37. 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		

38. Have you chosen to vaccinate your child?

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

If yes, any vaccine reactions?

_____

39. Has your child received any antibiotics?

- ○ Yes
- ○ No

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

Number of Antibiotics	Reason for Antibiotic	When (Date)	Age

41. Any difficulty with bonding or social development?

- ○ Yes
- ○ No

If yes, please explain:

_____

42. Night terrors or difficulty sleeping?

- ○ Yes
- ○ No

If yes, please explain:

_____

43. Behavioral, social or emotional issues?

○ Yes ○ No

If yes, please explain:

_____

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

_____

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

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

46. 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.

47.

	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