Pediatric Health Questionnaire

Account # __________________

Patient Name____**Today's Date:** _________________________

Referred by__________________________________ **Date of Birth:** ____/____/____ **Age:** _____________ **Gender:** M / F

Street Address: ____

City: _____________________________________ **State:** ______________ **Zip Code:** _____________________

Parent/Guardian 1: ____

Preferred Phone # (_____) ______-________ **E-Mail address:** ____

Parent/Guardian 2: ____

Preferred Phone # (_____) _____-_________ **E-Mail address:** ____

Insurance Co___________________________ **Policy Holder Name**______________________**Policy Holder DOB**___________

Consent for Treatment of a Minor

I hereby authorize LaBo Family Chiropractic to administer examinations and Chiropractic care as deemed necessary to my child.

Parent or Guardian's Name (printed): ____

Parent or Guardian's Signature: ____

Please share the names of your child's healthcare providers & check whether or not you would like to share medical records with:

Pediatrician ____ Midwife/OB _______________________________

Lactation consultant ___________________________________ Other _____________________________________

Parent/Guardian 1 Signature: ___________________________

Parent/Guardian 2 Signature: ___________________________

1. Describe your child's current symptoms :

____

____

____

2. How long? ____ **3. How frequent?** _________________________

4. What treatments have you tried for current symptoms? ____

5. What makes symptoms better? ____

6. What makes it worse? ____

7. Birth History: *(check all that apply)*

☐ Born premature? How Early? ______	☐ Vaginal birth at home	☐ Emergency cesarean
☐ Born on time ?	☐ Vaginal birth at Hospital	☐ Epidural used
☐ Born past due? How late? _______	☐ Vaginal birth at birthing center	☐ Forceps Used
☐ Induced labor	☐ Scheduled cesarean	☐ Vacuum extraction used

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8. Feeding History: *(check all that apply)*

☐ Nursed? How long? ________	☐ Both?	☐ Lip tie?
☐ Formula fed?	☐ Tongue tie?	☐ Lactation consultant used?

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9. Other History: *(check all that apply)*

☐ ADD/ ADHD	☐ Frequent fevers	☐ Headaches
☐ Frequent ear infections	☐ Sleeping problems	☐ Growing pains
☐ Constipation/Diarrhea	☐ Antibiotic Use	☐ Bed-wetting
☐ RSV	☐ Tonsillitis	☐ Up to date on vaccines
☐ Motor or speech delays	☐ Colic	☐ Modified/Delayed vaccine schedule
☐ Frequent Illness (cold/sick)	☐ Scoliosis	☐ Medical vaccine exemption
☐ Frequent crying spells	☐ Allergies / Asthma	☐ Religious vaccine exemption

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***10.* Pediatrician:** ______________________________ ***11.* Date of Last Medical Physical**______________________

12. Indicate if an immediate family member has had any of the following:

(1) Rheumatoid Arthritis (2) Heart Problems (3) Diabetes (4) Cancer (5) Lupus (6) Other: ___________

13. List all prescription and over-the-counter medications, nutritional/herbal supplements your child is taking:

____

____

14. List all the times your child has been hospitalized & all surgeries:

____

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15. ANY & ALL LIFETIME TRAUMA HISTORY to head, neck, or back (such as concussion, automobile accident, sports injury, etc.)...EVEN IF YOUR CHILD DID NOT HAVE ANY SYMPTOMS OR TREATMENT WITH THIS TRAUMA, STILL NOTE IT PLEASE.

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Parent/Guardian Signature____***Date***____________________________