PEDIATRIC QUESTIONNAIRE

LUKOWSKI FAMILY CHIROPRACTIC

Name: (Last, First MI)_______________________________ **Today's Date:** __________

PEDIATRIC REVIEW OF SYSTEMS

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

Childhood Diseases:
- ☐ Chicken Pox: Age ____
- ☐ Measles: Age ____
- ☐ Meningitis: Age ____
- ☐ Mumps: Age ____
- ☐ Rubella: Age ____
- ☐ Tuberculosis: Age ____
- ☐ Whooping Cough: Age ____
- ☐ Other:__________ Age ____
- ☐ *None in this Category*

Has your child been vaccinated?
☐ **No** ☐ **Yes**
*(Any Adverse Reactions? – Describe:)*_____________
____

INFANTS AND NEWBORNS

Prenatal History:

Location of Birth: ☐ Home ☐ Birthing Center ☐ Hospital

Birth Weight: ________ **Birth Length:** ________ **Full Term?** ☐ **No** ☐ **Yes** *(Describe)*______________________

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?)* _____ **Formula fed?** ☐ **No** ☐ **Yes** *(How Long?)* _____ *(Type?)* ________________

Introduced to cereal at ____ months old. **Solids at____ months old.** **Cow's milk 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

______________________________________ _______
Witness Date

Patient No: ___________

© Pinnacle Management Group, Inc. 2013