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 Dr. Tagliarini and whomever he/she may designate as assistants 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 Crying Spells	☐ Scoliosis
☐ Frequent Ear infections	☐ Frequent Fevers	☐ Allergies
☐ Constipation/Diarrhea	☐ Sleeping problems	☐ Headaches
☐ RSV	☐ Antibiotic Use	☐ Growing Pains
☐ Motor or Speech Delays	☐ Tonsillitis	☐ Bed Wetting
☐ Frequent Illness (cold/sick)	☐ Other _____	

***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:

_____

_____

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, STILL NOTE THE TRAUMA PLEASE.

_____

_____

Parent/Guardian Signature_____ ***Date***_____