

# 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 :**

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**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)**

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Born Premature? How Early _____ | <input type="checkbox"/> Vaginal birth at home            | <input type="checkbox"/> Emergency Cesarean     |
| <input type="checkbox"/> Born on time ?                  | <input type="checkbox"/> Vaginal birth at Hospital        | <input type="checkbox"/> Epidural used          |
| <input type="checkbox"/> Born Past Due? How Late? _____  | <input type="checkbox"/> Vaginal birth at Birthing Center | <input type="checkbox"/> Forceps Used           |
| <input type="checkbox"/> Induced labor                   | <input type="checkbox"/> Scheduled Cesarean               | <input type="checkbox"/> Vacuum extraction used |
- 

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

- |   |                                      |   |
|---|--------------------------------------|---|
| <input type="checkbox"/> Nursed? How Long _____ | <input type="checkbox"/> Both?       | <input type="checkbox"/> Lip Tie?                   |
| <input type="checkbox"/> Formula Fed?           | <input type="checkbox"/> Tongue Tie? | <input type="checkbox"/> Lactation Consultant Used? |
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**9. Other History: (check all that apply)**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> ADD/ ADHD                    | <input type="checkbox"/> Frequent Crying Spells | <input type="checkbox"/> Scoliosis     |
| <input type="checkbox"/> Frequent Ear infections      | <input type="checkbox"/> Frequent Fevers        | <input type="checkbox"/> Allergies     |
| <input type="checkbox"/> Constipation/Diarrhea        | <input type="checkbox"/> Sleeping problems      | <input type="checkbox"/> Headaches     |
| <input type="checkbox"/> RSV                          | <input type="checkbox"/> Antibiotic Use         | <input type="checkbox"/> Growing Pains |
| <input type="checkbox"/> Motor or Speech Delays       | <input type="checkbox"/> Tonsillitis            | <input type="checkbox"/> Bed Wetting   |
| <input type="checkbox"/> Frequent Illness (cold/sick) | <input type="checkbox"/> Other _____            |  |
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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:**

\_\_\_\_\_  
\_\_\_\_\_

**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** \_\_\_\_\_