Cohen Family Chiropractic
Healthy by choice, not by chance.

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PEDIATRIC QUESTIONARE

NEW PRACTICE MEMBER INFORMATION

Child's Name_____ Parent(s)/ Guardian(s) Name_____

Address_____ City_____ State_____ Zip_____

Home Phone _____ Work Phone _____ Cell Phone _____

Is it okay to contact you at work? ( ) Yes ( ) No

E-mail _____ Birthdate _____ Age ____

Have you or your child ever had chiropractic care before? ( ) Yes ( ) No
If yes, please tell us the doctor's name _____
Were you pleased with your care? ( ) Yes ( ) No

How did you find out about our office? _____

Is this appointment related to an auto accident? ( ) Yes ( ) No

Is your child receiving care from other health professionals? ( ) Yes ( ) No

Who is your family's primary care physician? _____

Please list any drugs or medications your child is taking _____
_____

Please list any vitamins/herbs/homeopathics/other your child is taking _____
_____

Please list any allergies your child has _____
_____

CURRENT HEALTH

Most children in our office are here for enhanced development and optimal function for body and mind.

If a health condition brings your child to our office, please describe._____

When did the symptoms first begin? _____

Is this condition ( ) Getting Worse ( ) Improving ( ) Intermittent ( ) Constant ( ) Not Sure

What makes the problem better? _____

What makes the problem worse? _____

Has your child been treated for this problem before? ( ) Yes ( ) No
Please explain _____

Does your child eat well? ( ) Yes ( ) No Does your child have regular bowel/bladder movements? ( ) Yes ( ) No

Has your child ever been checked for vertebral subluxations? ( ) Yes ( ) No ( ) Don't Know

HEALTH HISTORY

Child's birth was ( ) At home ( ) At a birthing center ( ) At a hospital

My obstetrician/midwife/family physician was _____

Child's birth was ( ) Natural vaginal (no medications/interventions)
( ) Vaginal with interventions
( ) Induction ( ) Pain medication ( ) Epidural ( ) Episiotomy ( ) Vacuum extraction ( ) Forceps
( ) Other _____
( ) C-section ( ) Scheduled ( ) Emergency

Please list reasons for any interventions/complications _____
_____

Child's birth weight _____ Child's birth height _____ Current weight _____ Current height _____

APGAR score at birth _____ APGAR score after 5 minutes _____

Was your child alert and responsive within 12 hours of delivery? ( ) Yes ( ) No
If no, please explain _____

At what age did the child:
Respond to sound _____ Follow an object _____ Hold head up _____ Vocalize _____
Sit alone _____ Teethe _____ Crawl _____ Walk _____
Patient/Hospitalization/ Surgical (please list below all surgeries and hospitalizations, including the year)
_____
_____

Please list any major injuries, accidents, falls, and/or fractures your child has sustained in his/her lifetime, including the year _____
_____

Is/was your child breastfed? ( ) Yes ( ) No If yes, how long? _____

Formula introduced at age _____ What type? _____

Introduction of cow's milk at age _____ Began solid foods at age _____

Please list any foods/juice intolerance _____

Did mother smoke during pregnancy? ( ) Yes ( ) No
Did mother drink alcohol during pregnancy? ( ) Yes ( ) No
Any illness of mother during pregnancy? ( ) Yes ( ) No
If yes, please explain including treatment/medications/supplements _____
_____

List any drugs/medications (including over the counter) taken during pregnancy _____
_____

List any supplements taken during pregnancy _____

Any exposures to ultrasound? ( ) Yes ( ) No If so, how many and what was the medical reason? _____
_____

Any pets at home? ( ) Yes ( ) No Any smokers at home? ( ) Yes ( ) No

GROWTH & DEVELOPMENT

Has child received any vaccinations? ( ) Yes ( ) No
If yes, which ones and list any reactions _____
_____

Has child received any antibiotics? ( ) Yes ( ) No If yes, how many times and list reasons _____
_____

Any difficulty with breastfeeding? ( ) Yes ( ) No If yes, please explain _____
_____

Any difficulty with bonding? ( ) Yes ( ) No If yes, please explain _____
_____

Any behavioral problems? ( ) Yes ( ) No If yes, please explain _____
_____

Any night terrors, sleepwalking or difficulty sleeping? ( ) Yes ( ) No If yes, please explain _____
_____

Age child began daycare_____ Average number of hours of TV per week _____

Does your child seem normal for their age? ( ) Yes ( ) No If no, please explain._____
_____

FAMILY HISTORY REVIEW

Check those involving immediate family and add identification: M=Mother, F=Father, S=Sibling, G= Grandparents

☐ Cancer, type _____
( ) M ( ) F ( ) S ( ) G

☐ Depression
( ) M ( ) F ( ) S ( ) G

☐ Diabetes
( ) M ( ) F ( ) S ( ) G

☐ Back problems
( ) M ( ) F ( ) S ( ) G

☐ Heart Disease
( ) M ( ) F ( ) S ( ) G

☐ Liver Disease
( ) M ( ) F ( ) S ( ) G

☐ High Blood Pressure
( ) M ( ) F ( ) S ( ) G

☐ High Cholesterol
( ) M ( ) F ( ) S ( ) G

☐ Lung Problems
( ) M ( ) F ( ) S ( ) G

☐ Scoliosis
( ) M ( ) F ( ) S ( ) G

☐ Neck Problems
( ) M ( ) F ( ) S ( ) G

☐ Osteoporosis
( ) M ( ) F ( ) S ( ) G

☐ Seizures
( ) M ( ) F ( ) S ( ) G

☐ Osteoarthritis
( ) M ( ) F ( ) S ( ) G

☐ Rheumatoid Arthritis
( ) M ( ) F ( ) S ( ) G

☐ Other _____
_____

CHIROPRACTIC

Do you know what subluxation is? ( ) Yes ( ) No

Do any of your friends or relatives see a chiropractor? ( ) Yes ( ) No

If yes, do they use chiropractic for ( ) Health maintenance/ optimization ( ) Health problems ( ) Both

Are you seeking chiropractic for ( ) Health maintenance/ optimization ( ) Health problems ( ) Both

What would you like to gain from chiropractic care? _____
_____

Are there other health concerns or anything else you'd like us to know about your child? _____
_____