

## PEDIATRIC HEALTH QUESTIONNAIRE

If your child is under 6 years old, please take the time to fill out this questionnaire as completely as possible. This will help us in the complete assessment of your child's spinal health.

Name: \_\_\_\_\_ Age: \_\_\_\_\_ years old

What is the purpose of this office visit? Spinal check-up

Other (please specify) \_\_\_\_\_

### PREGNANCY

Did you have any problems during pregnancy?

Toxemia Diabetes Pre-eclampsia Hypertension Water retention

Allergies Food sensitivities Nausea/vomiting Heartburn Back pain

Other (specify) \_\_\_\_\_

### DELIVERY

Was your child full term? Yes No # weeks early \_\_\_\_\_ # weeks late \_\_\_\_\_

How long was your labour? \_\_\_\_\_ hrs.

Were you induced? Yes No How? Vaginal Intravenous

Was any medication used? \_\_\_\_\_

Were any invasive procedures used? Episiotomy Epidural

Was your delivery: Vaginal C-section

Were any devices used in the delivery? Forceps Vacuum extraction

Other complications (specify) \_\_\_\_\_

### NEONATAL LIFE

Did the baby cry right away? Yes No

Apgar score \_\_\_\_\_ Birth weight \_\_\_\_\_ Present weight \_\_\_\_\_

Were there any problems following birth? Anoxia Jaundice Blood transfusions

Other (specify) \_\_\_\_\_

### INFANCY/CHILDHOOD

#### 1. Postural History

What position did/does your child sleep in? Side Back Front

Has your child ever had a postural analysis? Yes No

Has your child ever been suspected of having/diagnosed with any of the following?

Poor posture Scoliosis (spinal curvature) Kyphosis/Lordosis

Hip dysplasia Leg length inequality Flat feet Muscular torticollis

**2. Health History**

Has child ever been hospitalized? Yes No Reason\_\_\_\_\_

Has your child ever had surgery? Yes No Reason\_\_\_\_\_

Has your child ever experienced any of the following health problems?

Colic Allergies Asthma Bronchitis Pneumonia Recurrent colds/flu

Ear infections Seizures Diabetes Food/Drug Reactions

Other (specify)\_\_\_\_\_

Has your child had any of the following infectious childhood diseases?

Influenza Mumps Measles Rubella Poliomyelitis Chicken Pox

Meningitis Tuberculosis Hepatitis Mononucleosis

Other (specify)\_\_\_\_\_

Has your child been immunized? Yes No

Has your child ever had an adverse reaction to vaccines? Yes No

Explain\_\_\_\_\_

**3. History of Trauma**

Has your child ever had any of the following?

Fracture/dislocation concussion whiplash head trauma Sports injuries

Describe\_\_\_\_\_

Has your child had any falls? Yes No Describe\_\_\_\_\_

Has your child been involved in a car accident? Yes No Describe\_\_\_\_\_

**4. Chiropractic History**

Has your child had previous chiropractic care? Yes No

Dr.\_\_\_\_\_Reason\_\_\_\_\_

Previous x-rays? Yes No Date\_\_\_\_\_ Reason\_\_\_\_\_