Achieving Wellness Chiropractic Center LLC
Dr. Kerri Ward
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Port St. Lucie. FL 34986
772-344-1431

Pediatric Patient Questionnaire

Child's Name ____ Date ____________________

Parent(s)/Guardian(s) Names(s) ____

Address ____

City/State/Zip ____

Phone #s____________________(home) ________________________cell________________________(work)

Is it okay to contact you at work? Yes No

Email address____

Birth date_____________________________ Age____

Has 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 office visit related to an auto accident? Yes No

If this injury is related to an auto accident, please fill out the Auto Accident Form.

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

If yes, please name them and their specialty ____

Who is your family's primary care physician? ____

Please list any drugs or medications your child is taking ____

____

Please list any vitamins/herbs/homeopathic/other your child is taking______________________________________

____

Please list any allergies your child has ____

____

Current Health

What health condition brings your child to our office? ____

____

When did the symptoms first begin? ____

How did the problem start? suddenly gradually post-injury

Is this condition: getting worse improving intermittent constant not sure

What makes the problem better? ____

What makes the problem worse? ____

Has your child ever been treated for this condition before? Yes No

Please explain ____

Does your child drink water? Yes No How many ounces daily? ______________________________

Does your child eat well? Yes No How many fruits and vegetable servings daily?__________________________

Does your child have regular bowel/bladder movements? Yes No How many daily___________________________

Has your child ever been checked for VERTEBRAL SUBLAXATIONS? Yes No Don't Know

Birth 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 circle those that apply

induction pain medications epidural

episiotomy vacuum extraction forceps other____________________

C-section: scheduled emergency

Please list reasons for any interventions/complications ____

____

Child's birth weight & height____________________ Current weight & height ____________________________________

APGAR score at birth _________________________ APGAR score after 5 minutes ___________________________

Growth and Development

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 History(Please list below all surgeries and hospitalizations, including year) _________

____

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

____

Chemical Stressors

Is/ was your child breastfed? Yes No If yes, How long? _________________________________

Formula introduced at what age __________________ What type? ____

Introduction of cow's milk at age __________________ Began solid foods at age _____________________________

Please list any food/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 exposure to ultrasound? Yes No If so, how many and what was medical reason? _____________________

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

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 _______________________

____

Psychosocial Stressors

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/ 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=siblings G=grandparents

[ ] cancer (type) [ ] depression [ ] diabetes [ ] back problems

[ ] heart disease [ ] liver disease [ ] high blood pressure

[ ] high cholesterol [ ] lung problems [ ] scoliosis [ ] neck problems

[ ] osteoporosis [ ] seizures [ ] osteoarthritis [ ] rheumatoid arthritis

[ ] other ____

What do you know about Chiropractic?

Do you know what a subluxation is? Yes No

Are you seeking chiropractic for 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? ________________________

____

Financial Responsibility

Who is responsible for payment? ____

How will you pay for your care? Cash Check Credit Card

Insurance co. ____________________ Phone # ___________________________________

ID# ____________________________ Group # ___________________________________

Subscriber's name ____________________ Phone # ______________________________

Relation ____________________________ Subscriber's employer ___________________

Subscriber's SS #_____________________ Subscriber's birth date ___________________

The above is accurate to the best of my knowledge.

_____________________________________ _______________________________

(signature) (date)

Insurance Verification

Insurance verification and authorization is not a guarantee of payment. I understand that I may be responsible for any balance that is not paid by insurance. I authorize Achieving Wellness Chiropractic Center LLC / Dr. Kerri Ward to release any information regarding my treatment to any insurance company in effort to receive reimbursement for services provided. I authorize the use of my signature in all insurance submissions.

___________________________ _________________ __________________

Signature Date Parent (if patient is a minor)