PEDIATRIC PATIENT QUESTIONNAIRE

CONFIDENTIAL PATIENT INFORMATION

Child's Name: Parent/Guardian Name(s):

Street Address: City, State, Postal Code:

Cell Phone: Other Phone: Child's Sex: ○ M ○ F

Email: Child's: Birthdate: Age:

How did you hear about us?

Who is your primary care physician?

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

-If yes, please name them and their specialty:

Please list and drugs/medications/vitamin/herbs/other that your child is taking:

CURRENT HEALTH CONDITIONS

What health condition(s) bring your child to be evaluated?

When did the conditions first begin? How did the problem start? ○ Suddenly ○ Gradually ○ Post-Injury

Has your child ever received care for this condition before? ○ Yes ○ No

-If yes, please explain:

Is this condition: ○ Getting Worse ○ Improving ○ Intermittent ○ Constant ○ Unsure

What makes the problem better? What makes the problem worse?

Has your baby ever been assessed for oral ties by a professional?

-If yes, please list their occupation?

HEALTH GOALS FOR YOUR CHILD

What are your top three health goals for your child:

1. _____
2. _____
3. _____

What would you like to gain?

○ Resolve existing condition
○ Overall wellness
○ Both

Oral Health

Has your child ever been to the dentist? ○ Yes ○ No

Has your child ever has any of the following: ○ Cavities ○ Root Canal ○ Braces ○ Surgeries

-If yes please explain how many and procedures:

LABOR AND DELIVERY

Child's Birth was: ◯ Natural vaginal birth ◯ Scheduled C-section ◯ Emergency C-section ◯ At how many weeks was your child born?

Child's birth was: ◯ At home ◯ At a birthing center ◯ At a hospital ◯ Other:

Doctor/Obstetrician/Midwife Name:

Please check any applicable interventions or complications:

◯ Breech ◯ Induction ◯ Pain meds ◯ Epidural ◯ Episiotomy ◯ Vacuum extraction ◯ Forceps

Other:_____

Please describe any other concerns or notable remarks about your child's labor and/or delivery.

How was the umbilical cord at birth: ◯ Unwrapped loosely ◯ wrapped tightly ◯ knotted ◯ unknown

Child's birth weight: Child's birth height" APGAR score at birth: APGAR SCORE AFTER 5 MINUTES:

GROWTH & DEVELOPMENT HISTORY

Is/was your child breastfed? ◯ Yes ◯ No If yes, how long? Difficulty with breastfeeding? ◯ Yes ◯ No

Did they ever use formula? ◯ Yes ◯ No If yes, at what age? If yes, what type?

Did/does your child ever suffer from colic, reflux, or constipation as an infant? ◯ Yes ◯ No

-If yes, please explain:

Did/does your child frequently arch their neck/back, feel stiff, or bang their head? ◯ Yes ◯ No

If-yes, please explain:

At what age did the child: Respond to sound: _____ Follow an object: _____ Hold their head up: _____ Vocalize: _____ Teethe: _____

Sit alone: _____ Crawl: _____ Walk: _____ Roll over: _____ Begin cow's milk: _____ Begin solid foods: _____

Please list any food intolerance or allergies, and when they began:

Please list your child's hospitalization and surgical history, including the year:

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

Have you chosen to vaccinate your child? ◯ No ◯ Yes, on a delayed or selective schedule ◯ Yes, on schedule

-If yes, please list any vaccination reactions:

Has your child received any antibiotics? ◯ Yes ◯ No

-If yes, how many times and list reason and name of antibiotics:

Night terrors or difficulty sleeping? ◯ Yes ◯ No ◯ If yes, please explain:

ACKNOWLEDGEMENT & CONSENT

Patient Name: _____

Patient Signature: _____ Date: _____