LIFEForce Chiropractic

Patient questionnaire for newborns - toddlers age 0 - 2

Dear parents, the following questions are regarding your child and his/her health history. Your answers to these questions will help us determine and analyze the root cause of their health challenge. In order for us to give the exceptional care you expect for your child, please take your time in answering these questions and be as specific as you can.

_____

Name of your child Date of Birth

_____

Parents Name Best number to be reached

_____

Parents Email address

1. What brings you and your child to our office? Prevention or symptoms?

2. What are the symptoms and how long have they been there?

3. What is the overall health of your child/children? (common sicknesses, surgeries, falls, medicines, etc.)

4. Has your child been seen by another provider for this problem before? By whom and when?

5. Now or in the past, can your child turn their head to one side better than the other? If yes, which side is better?

6. Does your child dislike laying down?

7. Have you ever noticed an uneven head or face side to side?

8. Does your child cry/scream for more than 2 hours/day?

9. Is or was your child exclusively breast fed or were there problems with that?

10. If breastfeeding, does he/she breastfeed on both sides?

11. How often does he/she have bowel movements? Daily?

12. Do they have difficult bowel movements or lots of gas?

13. How was mothers health before the pregnancy and during the pregnancy?

14. How old were you during the pregnancy?

15. Was this your first pregnancy? If no, how many siblings are there and how old are they?

16. Did you partake in any alcohol, nicotine or coffee during the pregnancy? How much? Did you have to take medications? Y/N Which medicines and why?

17. Did you have complications or problems during your pregnancy?

18. How many weeks were you pregnant?

19. Did you, as parents, experience any increased stress during the pregnancy? If yes, please explain.

20. Did the birth of this child occur spontaneously or did you need help (medication or other) to get contractions started?

21. How long was the birth and where did you give birth (at home, hospital, birthing center)?

22. Were any instruments used during the birth (suction, forceps)? C-Section?

23. In what position was your baby born (face up, face down, breech)?

24. In what position did you deliver (on your back, birthing chair)?

25. Was the birth process traumatic for you?

26. Were you given any medication/drugs during birth?

27. What was your baby's birth weight? Head circumference? Length?

28. What was your baby's APGAR score?

29. What was your health status directly after the birth?

30. Who was the caring midwife after birth?

31. Who was the pediatrician after birth?

32. What are your expectations here at our clinic?

33. How did you find us?

Acknowledgement and Consent of a minor:

_____

Parent's signature of child (patient) Date