



Belleville Chiropractic and Wellness Center

1019 River St. Suite 5 Belleville, WI 53508

(608)424-1840

Pediatric Questionnaire (newborn-4 years)

Childs Name: _____, Your Mom: _____

Your Dad: _____

Prenatal History:

1. Tell us about your pregnancy;

Did you carry to full term?

Yes

No

Describe any complications and when they occurred: _____

Did you consume alcohol/smoke during your pregnancy?

Yes

No

Did you take any medication during your pregnancy?

Yes

No

Did you have any ultrasound during pregnancy?

Yes

No

Birth History:

2. Tell us about your delivery and birth of this child:

Did you use a midwife?

Yes No

Did you have a C-Section?

Yes No

Birth Trauma?

Doctor assisted

Vacuum Extraction

Forceps

Was labor induced?

Yes No

Did you have an Epidural?

Yes No

Was it a difficult birth?

Yes No

APGAR Score:

at birth_____/10

at 5 minutes_____/10

3. Tell us more:

Did you breastfeed? Yes No If yes, for how long? _____

If any, what formula did you use after? _____

4. As a baby/toddler, (birth to 4 years), did any of the following occur?

- | | |
|--|---|
| <input type="checkbox"/> Fall from a changing table | <input type="checkbox"/> Frequent crying spells |
| <input type="checkbox"/> Tumble down stairs | <input type="checkbox"/> Frequent fevers |
| <input type="checkbox"/> Fall out of a crib | <input type="checkbox"/> Frequent bouts of diarrhea |
| <input type="checkbox"/> Involved in a car accident | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Fall off playground equipment | <input type="checkbox"/> Sleeping problems |
| <input type="checkbox"/> Played in a Johnny jump up | <input type="checkbox"/> Frequent colds |
| <input type="checkbox"/> Frequent ear infections | <input type="checkbox"/> Colic |
| <input type="checkbox"/> Tonsillitis | <input type="checkbox"/> Did not gain weight |
| <input type="checkbox"/> Reaction to vaccination | <input type="checkbox"/> Other _____ |

Please explain the above: _____

5. Tell us about any vaccinations your child has had: _____

Any reactions to any of these? _____

Were you told that you had a choice in vaccinating your child? Yes No
Would you like information on the other side of this issue? Yes No

6. As a baby/toddler, (birth to 4 years), has your child experienced any of the following:

- | | |
|--|--|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Sleeping problems |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Stomach problems |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Weight gain/loss |
| <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> Bed wetting |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Allergies | |

Please explain any of the above: _____

7. Which of the problems you have checked off is the worst? _____

Is this problem: Constant Intermittent Occasional Cyclic

8. How long has it persisted? _____

9. When it is at its worst, how does it make your child feel? _____

10. What have you done about it that has NOT worked? _____

11. What makes it worse? _____

12. What effect does this problem have of your child's body functions?

On his/her participation in daily activities? _____

13. Describe any hospital stays: _____

14. Approximately how many times have antibiotics been prescribed and for
What conditions? _____

15. List any medications your child is currently taking: _____

16. To summarize, what is your purpose for this appointment? _____

17. Is there anything else you feel we should know? _____

Signature of parent or guardian: _____

Date: _____