Belleville Chiropractic and Wellness Center
PH: (608) 424 1840

1100 Bellwest Blvd
Belleville, WI 53508
Fax: (608) 424 1815

PEDIATRIC QUESTIONARE (NEWBORN – 4 YEARS)

Child's name: _____ Parent: _____

Parent: _____

Prenatal History

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

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 [ ]

Was labor induced? Yes [ ] No [ ]

Did you have an epidural? Yes [ ] No [ ]

Was it a difficult birth? Yes [ ] No [ ]

Birth trauma? Doctor assisted [ ] Vacuum extraction [ ] Forceps [ ]

APGAR score: at birth ____/10 at 5 minutes ____/10

Tell us more:

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

If any, what formula did you use after? _____

As a baby/toddler, did any of the following occur?

- ○ Fall from a changing table
- ○ Frequent fevers
- ○ Involved in car accident
- ○ Frequent colds
- ○ Tonsillitis
- ○ Fall off playground equipment
- ○ Frequent crying spells
- ○ Fall out of a crib
- ○ Constipation
- ○ Frequent ear infections
- ○ Did not gain weight
- ○ Sleeping problems
- ○ Tumble down stairs
- ○ Frequent bouts of diarrhea
- ○ Played in Johnny Jump Up
- ○ Colic
- ○ Reaction to vaccination
- ○ Other: _____

Please explain the above: _____

Tell us about any vaccinations your child has had: _____

_____

Were there any negative reactions to any of these? _____

Were you told that you had a choice in vaccinating your child? Yes [ ] No [ ]

Would you like the information on the other side of this issue? Yes [ ] No [ ]

As a baby/toddler, has your child experienced any of the following?

- ○ Headache
- ○ Asthma
- ○ Weight gain/loss
- ○ Sleeping problems
- ○ Hyperactivity
- ○ Bed wetting
- ○ Stomach problems
- ○ Fatigue
- ○ Other: _____
- ○ Dizziness
- ○ Allergies

Please explain any of the above: _____

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

Is this problem: Constant [ ] Intermittent [ ] Occasional [ ] Cyclic [ ]

How long has it persisted? _____

When it is as its worst, how does it make your child feel? _____

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

What makes it worse? _____

What effect does this problem have on your child's body functions? _____

_____

On his/her participation in daily activities? _____

Describe any hospital stays: _____

_____

Approximately how many times have antibiotics been prescribed and for what conditions?

_____

List any medications your child is currently taking: _____

_____

To summarize, what is your purpose of this appointment? _____

_____

Is there anything else you feel we should know? _____

_____

Signature of parent/guardian: _____ Date: _____