



Family Tree
chiropractic and
wellness

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Confidential Pediatric Questionnaire

Chart # _____ Date: _____

Name: _____ Age: _____ Birthday: ____/____/____

Mother's Full Name: _____ Father's Full Name _____

Address: _____ City: _____ State: _____ Zip: _____

Male Female Referred By: _____ E-mail: _____

of Siblings _____ Names: _____

By what name would you like to be called in the office? _____

Do you have Group Insurance? Yes No Company: _____

Purpose of this Appointment? _____

BIRTH QUESTIONS

Birth Weight: _____ Birth Length: _____

Type of Birth: Normal Vaginal Forceps Breech Cesarean Vacuum Extraction

Place of Birth: Home Birthing Center Hospital

Problems during Pregnancy: _____

Problems during Labor/Delivery: _____

Apgar Scores _____ (High 8-10) (Lower 25)

Was there presence at Birth of: q Jaundice (yellow) q Cyanosis (blue)

HEALTH QUESTIONS

Current Weight: _____ Birth Length: _____

Congenital Anomalies ? Defects: _____

Infant Feeding: Breast Bottle Formula

of hours sleep at night _____ Quality of Sleep: Good Fair Poor

Developmental History: At what age did the child

_____ Respond to sound _____ Sit Alone _____ Walk Alone

_____ Follow an object with eyes _____ Crawl _____ Stand

_____ Hold head up

Childhood Diseases:

Chickenpox Rubella Other _____

Mumps Measles _____

Whooping Cough

(Continued on Back)

Has this Child Ever Suffered From:

GENERAL

- ALLERGIES
- DIZZINESS
- EAR PROBLEMS (chronic aches)
- FATIGUE
- FREQUENT COLDS
- HEADACHES
- NOSE BLEEDS
- SINUS INFECTION
- SORE THROAT
- SUDDEN WEIGHT LOSS/GAIN
- TONSILLITIS
- FAINTING
- RHEUMATIC FEVER
- CONVULSIONS
- POOR APPETITE
- SINUS PROBLEMS

GENITO-URINARY

- FREQUENT URINATION
- BED-WETTING

CARDIO-VASCULAR

- HIGH-BLOOD PRESSURE
- HEART TROUBLE

GASTROINTESTINAL

- CONSTIPATION
- DIARRHEA
- DIGESTIVE DISORDERS
- NAUSEA & VOMITING
- STOMACH PROBLEMS

RESPIRATORY

- CHEST PAINS
- CHRONIC COUGH
- DIFFICULT BREATHING

MUSCLE & JOINT

- ARM PROBLEMS
- BROKEN BONES
- LEG PROBLEMS
- NECK PROBLEMS
- JOINT PROBLEMS

- BACKACHES
- WALKING PROBLEMS
- MUSCLE JERKING
- ORTHOPEDIC PROBLEMS
- "GROWING PAINS"
- NERITIS
- TERBERCULOSIS
- HYPERACTIVITY
- HYPERTENSION
- BEHAVIORAL PROBLEMS

EVER HAD:

- ANEMIA
- ARTHRITIS
- CANCER
- DIABETES
- HEART DISEASE
- ASTHMA
- PARALYSIS
- RUPTURES/HERNIAS
- _____

Immunization History: _____

Surgery: _____

Medications: _____

Accidents: _____

Family History: _____

Other Treating Physicians

OBSTETRICIAN/MIDWIFE _____	NAME	LOCATION
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PEDIATRICIAN/FAMILY M.D. _____	NAME	LOCATION
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AUTHORIZATION FOR CAR OF A MINOR

I HEREBY AUTHORIZE THIS CLINIC AND IT'S DOCTOR(S) TO ADMINISTER CARE AS THEY DEEM NECESSARY TO MY SON/DAUGHTER/WARD (UPON APPROVAL OF PARENT OR GUARDIAN)

NAME: _____ SIGNED: _____ DATE ___/___/___

WITNESS: _____ DATE ___/___/___

I REALIZE THAT I AM RESPONSIBLE FOR ALL FEES AND CHARGED BY THIS CLINIC AND THAT I WILL PAY FOR ALL SERVICES AS THEY ARE PERFORMED. X-RAY'S REMAIN THE PROPERTY OF THIS CLINIC.

SIGNATURE: _____ DATE ___/___/___