Marin Chiropractic Studio
1115 Irwin St. Suite 200
San Rafael, CA 94901
Call:415-295-5290
Email: info@marinchiropracticstudio.com

Pediatric Patient Health Questionnaire

Patient Name:	**Date:**
Parent's Name:	
Address:	**DOB:**
City ST	**Age:**
Home Phone:	**Work Phone:**
E-mail Address:	

What is the reason for your child's visit?

How long have they had this problem?

Please list the names of other healthcare practitioners seen for this condition:

Please indicate any of the following health concerns experienced currently or in the past:

- ☐ Allergies (please indicate) ____________________
- ☐ Anemia
- ☐ Anxiety, reoccurring
- ☐ Heart palpitations
- ☐ Insomnia
- ☐ Nasal Congestion
- ☐ Skin rash/eruptions
- ☐ Urination problems
- ☐ Diarrhea
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Generalized Fatigue
- ☐ Flatulence
- ☐ Headaches, reoccurring
- ☐ Heart Disease
- ☐ Asthma
- ☐ Kidney Disease
- ☐ Pneumonia
- ☐ Bleeding disorders
- ☐ Cancer
- ☐ Diabetes
- ☐ Anaphylaxis
- ☐ Fainting
- ☐ Heartburn

Please list any other major health problems that are not listed above:

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Family History

Please indicate if you have a family history of any of the following (including grandparents, parents & siblings)

- ❑ Diabetes
- ❑ Heart Disease
- ❑ Stroke
- ❑ Cancer
- ❑ Obesity
- ❑ Hypertension
- ❑ Asthma
- ❑ Early death

Please indicate any other valuable information concerning your family's health not listed above:

Pregnancy and Birth

Please list any complications experienced during your pregnancy with this child:

Did you use tobacco products with this pregnancy?

Did you use drugs/alcohol during this pregnancy?

Gestationally, how many weeks was your child when they were born?

Was your child delivered vaginally or via c-section?

Were there any interventions (medications, forceps, vacuum) used during birth?

Is your child vaccinated? Yes No
If so, please list vaccines received:

Concerning your child's diet:

As an infant was your child (check one):
- ❑ Exclusively breastfed
- ❑ Breastfed and supplemented with formula
- ❑ Exclusively formula-fed

Additional comments:

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If applicable: What foods primarily make up your child's diet:

Please list any supplements your child is taking:

Are they pharmaceutical grade? Yes No Unsure

Please list any prescription medications your child is taking:

If you are currently breastfeeding, please complete the next section:

About how many caffeinated beverages do you consume in a week?

0 1-5 6-10 11-15 20+

About how many alcoholic beverages do you consume in a week?

0 1-5 6-10 11-15 20+

Do you use tobacco products? Yes No
If so, for how many years? ______________
On average, how much per week? ___________________

What foods primarily make up your diet?

About how many servings of fresh fruits and vegetables do you eat in a day?

0 1-5 6-10 11+

About how many glasses of water do you drink in a day?

Do you filter your drinking water?

What types of foods do you crave?

Please list any supplements you take daily:

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Are they pharmaceutical grade? Yes No Unsure

Please list any prescription medications you are taking:

How willing are you to change your lifestyle for your child's health?