OUTTEN CHIROPRACTIC
401 High House Rd., Suite 110
Cary, NC 27513

Date:_____

Confidential Pediatric Questionaire

Please complete this form as accurately as possible. Your answers will help us determine whether chiropractic care can help your child. Thank you for your cooperation.

Name:_____ Age:_____ Date of Birth:_____
Mothers Full Name:_____ Fathers Full Name:_____
Address:_____ City:_____ State:_____ Zip:_____
Telephone: (Home):_____(Work):_____ Social Security #:_____
O Male O Female Referred by:_____ Email Address:_____
Number of Siblings:____ Names:_____
By what name would he/she like to be addressed in the office (nickname):_____
Do you have health insurance? O Yes O No Company:_____
Purpose of this appointment:_____

Birth Questions

Birth Weight:_____ Birth Length:_____
Type of Birth: O Normal Vaginal O Forceps O Breech O Cesarean O Vacuum Extraction
Place of Birth: O Home O Birthing Center O Hospital
Problems during preganancy:_____
Problems during labor/delivery:_____
Apgar Score:_____ High 8-10 Low 2-5
Was there presence at birth of O Jaundice (yellow)or O Cyanosis (blue)?

Health Questions

Current Weight:_____ Current Length:_____
Congenital Anomalies? Defects:_____
Infant Feeding: O Breast O Bottle O Formula
# of hours of sleep per night:_____ Quality of sleep: O Good O Fair O 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 ____Mumps ____Measles ____Rubella ____Whooping Cough Other:

Has this child ever suffered from:

General:

____Allergies ____Dizziness ____Ear Problems ____Fatigue ____Headaches
____Nose Bleeds ____Sinus Infections ____Sore Throat
____Sudden Weight Loss or Gain ____Tonsillitis ____Fainting
____Rheumatic Fever ____Convulsions ____Poor Appetite ____Sinus Problems

Genito-Urinary:

____Frequent Urination ____Bedwetting

Cardio-Vascular:

____High Blood Pressure ____Heart Trouble

Gastrointestinal:

____Constipation ____Diarrhea ____Digestive disorders ____Nausea & Vomiting
____Stomach problems

Respiratory:

____Chest Pain ____Chronic Cough ____Difficulty Breathing

Muscle & Joint:

____Arm Problems ____Broken Bones ____Leg Problems ____Neck Problems
____Joint Problems ____Backaches ____Walking Problems ____Muscle Jerking
____Orthopedic Problems ____"Growing Pains" ____Tuberculosis
____Hyperactivity ____Hypertension ____Behavioral Problems
____Anemia ____Arthritis ____Cancer ____Diabetes
____Heart Disease ____Asthma ____Paralysis ____Ruptures/Hernias

Immunization History:_____
Surgeries:_____
Medications:_____
Accidents:_____
Family History:_____

Other Treating Physicians:

Obstetrician/Midwife:_____
Name Location
Pediatrician/Family MD:_____
Name Location

Authorization for care 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)

Signed:_____ Witnessed:_____ Date:_____

I realize that I am responsible for all fees charged by this clinic and that I will pay for all services as they are performed. X-rays remain the property of this clinic.

Signed:_____ Date:_____