



# OUTTEN CHIROPRACTIC

The Right Steps to Health and  
Wellness through Chiropractic Care

201 W. Chatham Street Ste. 106 ~ Cary, NC 27511

Date: \_\_\_\_\_

## Confidential Pediatric Questionnaire

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

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Birthday: \_\_\_\_\_  
 Mother's Full Name: \_\_\_\_\_ Father's Full Name: \_\_\_\_\_  
 Address: \_\_\_\_\_ City or Town: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Telephone # (Home): \_\_\_\_\_ (Work) \_\_\_\_\_ Social Security: \_\_\_\_\_  
 MALE  FEMALE Referred By: \_\_\_\_\_ E-mail Address: \_\_\_\_\_  
 Number of Siblings: \_\_\_\_\_ Names: \_\_\_\_\_  
 By what name would you like to be addressed in our 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  Jaundice (yellow)  Cyanosis (blue)?

### Health Questions

Current Weight \_\_\_\_\_ Current Length \_\_\_\_\_  
 Congenital Anomalies? Defects: \_\_\_\_\_  
 Infant Feeding:  BREAST  BOTTLE  FORMULA  
 No. 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  Rubella \_\_\_\_\_  
 Measles  Whooping Cough \_\_\_\_\_

**Has this Child Ever Suffer From:**

GENERAL

- ALLERGIES
- DIZZINESS
- EAR PROBLEMS (CHRONIC ACHES)
- FATIGUE
- FREQUENT COLDS
- HEADACHES
- NOSE BLEED
- SINUS INFECTION
- 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
- DIFFICULT BREATHING

MUSCLE & JOINT

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

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

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

Immunization History: \_\_\_\_\_

Surgery: \_\_\_\_\_

Medications: \_\_\_\_\_

Accidents: \_\_\_\_\_

Family History: \_\_\_\_\_

**Other Treating Physicians:**

OBSTETRICIAN /MIDWIFE \_\_\_\_\_

NAME

LOCATION

PEDIATRICIAN / FAMILY M.D. \_\_\_\_\_

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.

DATE \_\_\_\_/\_\_\_\_/\_\_\_\_ SIGNATURE \_\_\_\_\_