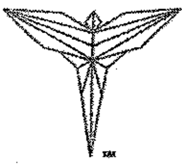

Southwest Back Clinic
4241 Southwest Blvd. Ste 106
325-947-2225

PEDIATRIC CHIROPRACTIC WELLNESS SURVEY

Child's Name: ______________________ Date: ______________________

DOB: ______________________ Gender: ☐Male ☐Female

Parent/Guardian's Name: ______________________ Phone: ______________________

Address: ______________________ City, State & Zip: ______________________

Siblings Names & Ages: ______________________

Reason for seeking chiropractic care? ______________________

Who can we thank for referring you? ______________________

Date of last MD visit and reason? ______________________

Any health concerns? ______________________

Has your child undergone care for any conditions? (Please include medications) ______________________

____

Birth Location: ☐Home ☐Birth Center ☐Hospital Birth Provider: ☐Midwife ☐OBGYN

Duration of pregnancy: ______ weeks Assisted Birth? ☐Induced Labor ☐C-Section ☐Vacuum ☐Forceps

Birth Weight: ____________ Length: ____________

Any medications during labor/delivery? ☐Yes ☐No If yes, which ones? ______________________

____

Duration of labor/active labor? ________/________

Any complications at birth? ☐Yes ☐No If yes, please describe: ______________________

Was your baby alert and responsive within 12 hours of birth? ☐Yes ☐No If no, please explain: ______________________

____

Do sleeping patterns seem normal to you? ☐Yes ☐No If no, please explain: ______________________

____

How many wet diapers in a day? __________ How many dirty diapers in a day? __________

What is your baby's diet like? (Breastfeeding times, oz of milk, solids, etc.) ______________________

____

Since the health of the nervous system can be affected by many types of stressors, the following information is very important:

CHEMICAL STRESSORS:

Was baby breast fed? ☐Yes ☐No For how long? ____________

Was formula every introduced? ☐Yes ☐No If yes, at what age/type used? ____________/____________

Was there introduction of cow's milk? ☐Yes ☐No If yes, at what age? ____________

Food/Juice intolerance? ☐Yes ☐No If yes, what type? ____________

During pregnancy, did the mother smoke? ☐Yes ☐No Did the mother drink alcohol? ☐Yes ☐No

Any illness of the mother during pregnancy? ☐Yes ☐No Any drugs taken during pregnancy? ☐Yes ☐No

Any exposures to ultrasound? ☐Yes ☐No If yes, how many times? ____________

Any invasive procedures (amniocentesis, CVS)? ☐Yes ☐No

Any smokers in the home? ☐Yes ☐No How much exposure? ____________

Any vaccinations? ☐Yes ☐No If so, which ones and any reactions? ____________

____

Any antibiotics? ☐Yes ☐No If yes, please explain: ____________

Total number of courses of antibiotics to date: ____________

PSYCHOSOCIAL STRESSORS:

Any difficulties with nursing? ☐Yes ☐No If yes, please explain: ____________

Any problems with bonding? ☐Yes ☐No If yes, please explain: ____________

Any behavioral problems? ☐Yes ☐No If yes, please explain: ____________

Any night terrors, sleeping walking, difficulty sleeping? ☐Yes ☐No If yes, please explain: ____________

Average number of hours of screen time (iPad, TV, etc) per week: ____________

TRAUMATIC STRESSORS:

Any traumas during pregnancy (falls, accidents)? ☐Yes ☐No If yes, please explain: ____________

Any evidence of birth trauma? (bruises, odd shaped head, stuck in birth canal, excessively long birth, respiratory depression, cord around neck, other) ☐Yes ☐No If yes, please explain: ____________

Any falls from couches, bed, change tables? ☐Yes ☐No If yes, please explain: ____________

Any traumas with bruising, cuts, stitches, fractures? ☐Yes ☐No If yes, please explain: ____________

Any hospitalizations? ☐Yes ☐No If yes, please explain: ____________

Any surgeries or organs removed? ☐Yes ☐No If yes, please explain: ____________

Sports played & age began? ____________ Hours per week played? ____________

Weight of school backpack? ____________

Has your child ever received chiropractic care? ☐Yes ☐No Date of last adjustment: ____________

Who was your child's last chiropractor? ____________ Frequency of visits: ____________ Duration of care: ____________

Please add any additional comments or questions: ____________

____