Pediatric Questionnaire Form

Today's Date ____________________ Referred by____
Child's Name____________________ DOB____
Mother's name___________________ Father's name____
Telephone @ Home________________ Work___________________Cell__________________________
Address____
Pediatrician_____________________ Telephone____
Insurance Company _______________ Telephone____
School ___________________________Telephone _______________Teacher_____________________
Emergency Contact ______________________Telephone____

GENERAL HEALTH HISTORY

Describe your pregnancy, labor, delivery____
____
Was your child ☐ Full term ☐ Premature Gestational Age _____Birth weight__________________
Has your child ever been hospitalized? ☐ Yes ☐ No
Explain____
Was your child ☐ Breast fed ☐ Bottle fed? Did child transition easily to solid food? ☐ Yes ☐ No
At what age did your child? Sit ________Crawl ________Walk ________Talk________
____
Who lives in the home?_____________________
Any developmental issues or illnesses in family?____
Has your child ever been treated for?

☐ Asthma ☐ Allergies ☐ Ear infections ☐ Feeding Problems ☐ Food hypersensitivities
☐ Gastrointestinal Problems ☐ Headaches ☐ Major illness or injury ☐ Seizures
☐ Sensory or motor issues ☐ Sleep Problems ☐ Other______________________________

Comments____
____
____

Has your child seen any of the following specialists?

☐ Developmental Pediatrician ☐ Neurologist ☐ Psychiatrist ☐ Audiologist
☐ Occupational Therapist ☐ Physical Therapist ☐ Speech and Language Therapist
☐ Neuropsychologist ☐ Osteopath ☐ Chiropractor
☐ Homeopath ☐ Nutritionist
☐ Psychotherapist ☐ Special Educator

____
Areas of concern____
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Please Note: Your health information will be kept confidential. Any information that we collect about you on this form will be kept confidential in our office.

_________________________ _________________________ _________________________
Name of Parent/Legal Guardian Signature Date