CHILD QUESTIONNAIRE

Full Name: Date of Birth: Date:

Name's of Parents or legal guardians:

Address:

Home Phone: Cell Phone: Work Phone:

Regarding your child's birth (If unsure, leave blank)…

❑ Difficult Delivery ❑ Forceps Extraction ❑ Delivered C-Section ❑ Breach Birth
❑ Induced Labor ❑ Hospital Birth ❑ Home Birth ❑ Natural Birth
❑ Full term ❑ Pre-mature ❑ Post-term

Birth Weight: Birth Size:

Regarding your child's growth and development (Check all that apply)…

❑ Breast Fed ❑ Colic ❑ Trouble Sleeping ❑ Feeding Difficulties
❑ Digestive Problems ❑ Allergies ❑ Frequent Fevers ❑ Ear Infections

Describe any major traumas or accidents:

Describe any surgeries:

Describe any illnesses or medications:

Describe any known allergies:

Regarding your child's current condition…

What is your reason for seeking care?

When did this condition begin:

What do you think is the cause of this condition?

When is this condition better or worse?

Have you seen any other doctors for this condition?

Are you using any medications to manage this condition?

The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine my child for further evaluation:

Signature of Parent or Legal Guardian Date