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Boone, IA 50036

Khan Chiropractic PLLC

Phone # 515-212-8939

Pediatric and Children Patient Questionnaire

Patient Information:

Childs Name _____ Parent/Guardian's Name: _____

Address: _____City: _____ State: _____ Zip: _____

Phone Number: _____ Email: _____

Birthdate: _____ Age: _____

Is your child receiving care from other health professionals? YES | NO
If yes, what is their specialty: _____

Please list any medications, vitamins, herbs, others that your child is taking:

_____

What health care conditions bring your child in to be seen by the doctor today:

_____

When did, the condition start: _____ How did the problem start: Gradually | suddenly | post-injury

Has your child received care for this condition before? YES | NO
If yes, please explain: _____

Is your child's condition: Getting worse | Improving | Intermit | Consent | Unsure

What makes the condition better? _____
What makes the condition worse? _____

What would you like to gain from chiropractic care: help existing condition | overall wellness
Have you seeked chiropractic care before? YES | NO If yes, from who? _____

Pregnancy and Fertility History -Please tell us about your pregnancy here

Any fertility issues: YES | NO Please explain:_____
Did the mother smoke: YES | NO If so, how many per week:_____
Did the mother drink: YES | NO If so, how many per week: _____
Did the mother exercise: YES | NO If so, how much per week:_____
Was the mother ill: YES | NO If so, explain:_____

Parent Signature:_____ Date:_____