**SCOTT S. SARDONICUS, DC**

**215 BROWNS RIDGE RD; OSSIPEE NH 03864**

# PEDIATRIC REVIEW & UPDATE QUESTIONNAIRE

Child's Name: ______________________________________________ Date: ____________________

Parent filling out this form: ______________________________________________

What changes have you noticed (positive or negative) since beginning care?

On a scale of 0-10 where 0 is no change and 10 is AWESOME, how would you rate your level of improvement so far?

Would you say your improvement is:

___ Progressing at the speed you expected ___ Progressing faster than you expected ___ Taking longer than expected

Rate your child's ability to perform your normal activities (school, play, sports, chores, sitting, walking, sleeping etc) where 0 is unable and 10 is AWESOME:

Describe any limitations:

HOW WOULD YOU RATE YOUR CHILD'S WELLBEING?

*Please rate each of the following areas on a scale of 0-10 (0=terrible; 10=awesome)*

_______ Energy level
_______ Ease of movement
_______ Ease of respiration
_______ Overall wellness
_______ Quality of sleep
_______ Amount of sleep
_______ Ability to focus
_______ Happiness / joy
_______ Ease of digestion
_______ Time in nature
_______ Getting along with others
_______ Strength & endurance

Rate your child's level of stress (0-10; 10 is highest): ______

What causes stress? (ie school, family issues, health etc)

Rate your child's level of overall vitality (0-100%): ________

If less than 100%, why?

What does your child do for exercise and how often? (ie walking, running, biking, swimming, yoga etc)

What does your child do for stress management and how often? (ie dance, meditate, yoga, reading, listen to music, sports etc)

How many hours of sleep does your child get each night? ________ Is it enough? Y N If no, why?

Please tell us what type of care you are most interested in your child receiving:

☐ Relief care: for the relief of pain/symptoms only; will not correct what caused the pain.

☐ Corrective: to feel better and *stay* better, and strengthen and heal the spine; this may take several months to several years depending on the condition of your child's spine and nervous system.

☐ Maintenance: Periodic checkups to maintain an already healthy spine.

Have you been consistent with the outlined treatment plan? ☐ Y ☐ N

## SPECIFIC HEALTH CONCERNS

*Please update the severity, frequency, and duration for any pre-existing concerns, or if it is no longer a concern please note the date of last occurrence. Please add any new concerns, and include LOCATION and QUALITY (dull, sharp, burning, achy, tingly, etc) when applicable. Rate severity on a scale of 1-10 where 10 is worst (for example, "constant 2/10 and up to 5/10 twice a day for 30 min" or "4/10 daily until 5 min after I lie down").*

| Location/Description | Severity | Frequency | Duration | What helps? | Makes it worse? | When & how did it start | Last time it happened? |
|---|---|---|---|---|---|---|---|
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |

Do your child have any new health care providers? (ie medical doctor, physical therapist, naturopath, acupuncturist, massage therapist etc) Please list name, address, reason for care, results:

List any medications, supplements or medicinal herbs *[including reason where applicable]*:

Please check Yes or No as the following applies to your child. *Please indicate how much and how often.*

☐Y ☐N Drink water ____________________
☐Y ☐N Whole grains ____________________
☐Y ☐N Fresh vegetables ____________________
☐Y ☐N Green vegetables ____________________
☐Y ☐N Fresh fruit ____________________
☐Y ☐N Fruit juice ____________________

☐Y ☐N Sweets ____________________
☐Y ☐N White sugar ____________________
☐Y ☐N Artificial sweeteners ____________________
☐Y ☐N Dairy products ____________________
☐Y ☐N Soda ____________________
☐Y ☐N Junk food ____________________

Does your child's diet include sources of Omega-3 Essential Fatty Acids? ☐ No ☐ Yes *[please indicate source, frequency, amount]*

______________________________________________________________________

Does your child's diet include any sources of probiotics (fermented foods or supplemented)? ☐ No ☐ Yes *[source, frequency, amount]*

______________________________________________________________________

Are there any dietary improvements that you would like to make or are currently working on?

______________________________________________________________________

Current health goals:

Additional comments/concerns: