Initial Child & Adolescent Questionnaire

Your Name: _____ Your Mom: _____

Address: _____ Your Dad: _____

_____ Birth Date: M____ D____ Y_____

Phone:_____ Cell:_____ Email:_____

Mainly for Moms:

1. Tell us about your pregnancy;

Did you carry to full term? _____

Describe any complications and when they occurred: _____

_____

_____

2. Tell us about your delivery and birth of this child:

Did you use a midwife? _____ Hospital? _____ Obstetrician? _____

Did you have a C-Section? _____ Were forceps used? _____

Vacumn Extraction? _____ Were you induced? _____

Did you have an Epidural? _____ Was it a difficult birth? _____

What was the baby's **APGAR** Score? _____ At 5 minutes? _____

3. Tell us more:

Did you breastfeed? _____ How long? _____ What formula after?_____

Did you consume alcohol during your pregnancy? _____ How much? _____

Did you smoke? _____ How much? _____ How long? _____

Did you take any medication during your pregnancy?

For what? _____ What type? _____

Any exposure to ultrasound?_____How many?_____

4. As a baby/toddler, (birth to 4 years), did any of the following occur?

___ Fall from a change table	___ Frequent crying spells
___ Tumble down stairs	___ Frequent fevers
___ Fall out of crib	___ Frequent bouts of diarrhea
___ Involved in car accident	___ Constipation
___ Fall off playground equipment	___ Sleeping problems
___ Play in Jolly Jumper	___ Frequent colds
___ Frequent ear infections	___ Colic
___ Tonsillitis	___ Did not gain weight
___ Reaction to vaccination	___ Other_____

Please explain the above: _____

_____

5. As a young child, (5-12 years), did any of the following occur?

___ Fall from a tree	___ Bed wetting
___ Fall of a bicycle	___ Hyperactivity/Autism
___ Fall of playground equipment	___ Learning difficulties
___ Sports accident	___ Asthma
___ Car accident	___ Allergies
___ Stomach pains	___ Leg/knee pains
___ Scoliosis	___ Other_____

Please explain the above: _____

_____

6. Tell us about any vaccinations your child has had: _____

_____

Any reactions to any of these? _____

Were you told that you had a choice in vaccinating your child? ___**YES** ___**NO**
Would you like information on the other side of this issue? ___**YES** ___**NO**

7. As a child or adolescent, has your child experienced any of the following:

___ Headaches	___ Numbness in arms/hands	___ Foot/ankle/knee pains
___ Dizziness	___ Arm/wrist pains	___ Tingling in arms/legs
___ Ringing in ears	___ Sleeping problems	___ Neck/back pains
___ Asthma	___ Allergies	___ Shoulder pains
___ Hyperactivity	___ Stomach problems	___ Growing Pains
___ Fatigue	___ Weight gain/loss	___ Other

Please explain any of the above: _____

_____

8. Which of the problems you have checked off is the worst? _____
Is this problem: Constant **____,** intermittent **____,** Occasional **____,** Cyclic **_____**

9. How long has it persisted? _____

10. **When it is at its worst, how does it make your child feel?** _____

11. **What have you done about it that has NOT worked?** _____

12. **What makes it worse** _____

13. **What effect does this problem have on your child's body functions**?

_____

_____

On his/her participation in daily activities? _____

Describe any hospital stays: _____

_____

14. **Approximately how many times have antibiotics been prescribed and for what conditions?** _____

_____

15. **List any medications your child is currently taking:** _____

_____

16. **To summerize, what is your purpose for this appointment?** _____

_____

_____

18. **Is there anything else you feel we should know?** _____

_____

_____

Signature of parent or guardian: _____

Date: _____