main family
CHIROPRACTIC CENTRE

Initial Child & Adolescent Questionnaire

Your Name: _____ Your Parents: _____

Address: _____ : _____

_____Postal Code _____ Birth Date: M____ D____ Y_____

Phone:_____ Cell:_____ Email:_____

Mainly for Moms:

Tell us about your pregnancy;

Did you carry to full term? _____

Describe any complications and when they occurred: _____

_____

_____

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? _____

Vacuum Extraction? _____ Were you induced? _____

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

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

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?_____

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

___ Fall from a change table
___ Tumble down stairs
___ Fall out of crib
___ Involved in car accident
___ Fall off playground equipment
___ Play in Jolly Jumper
___ Frequent ear infections/tubes
___ Tonsillitis
___ Frequent crying spells
___ Frequent fevers
___ Frequent bouts of diarrhea
___ Constipation
___ Wakes frequently during the night
___ Frequent colds
___ Colic
___ Acid Reflux/Vomiting
___ Other_____

Please explain the above: _____

_____

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

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

Please explain the above: _____

_____

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

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

Please explain any of the above: _____

_____

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

How long has it persisted? _____

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

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

What makes it worse? _____

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

_____

_____

On his/her participation in daily activities? _____

Describe any hospital stays: _____

_____

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

_____

List any medications your child is currently taking: _____

_____

Is there anything else you feel we should know? _____

_____

_____

Statement of Acknowledgement/Consent

I, _____, authorize Dr. Jennifer Tremain to examine and
(Parent/Guardian)
administer Chiropractic care and treatment to _____,
(Child's Name)
whose relationship to me is as a _____. I have been given an explanation of and understand the nature of the Chiropractic care and treatment. I accept full responsibility for any fees incurred during care. I understand that I am free to withdraw my consent and to discontinue participation in this care program at any time.

Signature of parent or guardian: _____

Date: _____