Initial Child & Adolescent Questionnaire

Child's Name: _____ Parents:_____

Child's Birthdate: _____ Care Card Number : _____

Address: _____ Phone #:_____

Email: _____

Mainly for Moms

1. Tell us about your pregnancy:_____

_____

Describe any complications and when they occurred: _____

_____

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

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

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

Did you have a 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? _____

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 exposures to ultrasound? _____How many?_____

4. 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 a Jolly Jumper

_____ Frequent ear infections

_____ Tonsilitis

_____ Reaction to vaccination

_____ Frequent crying spells

_____ Frequent fevers

_____ Frequent bouts of diarrhea

_____ Constipation

_____Sleeping problems

_____Frequent colds

_____ Colic

_____ Did not gain weight

_____ Other _____

Please explain the above: _____

_____

_____

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

_____Fall from a tree

_____ Fall off a bicycle

_____ Fall off playground equipment

_____ Sports accident

_____ Car accident

_____ Stomach pains

_____ Scoliosis

_____ Bed wetting

_____ Hyperactivity/Autism

_____ Learning difficulties

_____ Asthma

_____ Allergies

_____ Leg/knee pains

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 sides 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 _____

14. Describe any hospital stays:_____

_____

_____

15. Approximately how many times have antibiotics been prescribed and for what conditions? __

_____

_____

16. List any medications your child is currently taking: _____

_____

_____

17. To summarize, what is your purpose for this appointment? _____

_____

_____

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

_____

_____

Signature of parent or guardian: _____

Date: _____