



Initial Child & Adolescent Questionnaire

Child Name: _____ Mom: _____

Address: _____ Dad: _____

_____ Phone #: _____

Cell Phone Provider : _____

Child's Birthday: ____/____/____ Male Female Email: _____

Mainly for Mom or Dad:

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? _____

Vacuum Extraction? _____ Were you induced? _____

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

What was the baby's **APGAR** Score initially? _____ 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?

- | | |
|--|---|
| <input type="checkbox"/> Fall from a change table | <input type="checkbox"/> Frequent crying spells |
| <input type="checkbox"/> Tumble down stairs | <input type="checkbox"/> Frequent fevers |
| <input type="checkbox"/> Fall out of crib | <input type="checkbox"/> Frequent bouts of diarrhea |
| <input type="checkbox"/> Involved in car accident | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Fall off playground equipment | <input type="checkbox"/> Sleeping problems |
| <input type="checkbox"/> Play in "Jolly Jumper" | <input type="checkbox"/> Frequent colds |
| <input type="checkbox"/> Frequent ear infections | <input type="checkbox"/> Colic |
| <input type="checkbox"/> Tonsillitis | <input type="checkbox"/> Did not gain weight |
| <input type="checkbox"/> Reaction to vaccination | <input type="checkbox"/> Other _____ |

Please explain the above: _____

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

- | | |
|--|--|
| <input type="checkbox"/> Fall from a tree | <input type="checkbox"/> Bed wetting |
| <input type="checkbox"/> Fall off a bicycle | <input type="checkbox"/> Hyperactivity/Autism |
| <input type="checkbox"/> Fall off playground equipment | <input type="checkbox"/> Learning difficulties |
| <input type="checkbox"/> Sports accident | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Car accident | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Stomach pains | <input type="checkbox"/> Leg/knee pains |
| <input type="checkbox"/> Scoliosis | <input type="checkbox"/> 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:

- | | | |
|--|---|--|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Numbness in arms/hands | <input type="checkbox"/> Foot/ankle/knee pains |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Arm/wrist pains | <input type="checkbox"/> Tingling in arms/legs |
| <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Sleeping problems | <input type="checkbox"/> Neck/back pains |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Allergies | <input type="checkbox"/> Shoulder pains |
| <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> Stomach problems | <input type="checkbox"/> "Growing Pains" |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Weight gain/loss | <input type="checkbox"/> 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? _____

I _____ being the parent or legal guardian of _____

have read and fully understand that I give my consent to an evaluation and care of the minor child named above and, I hereby grant permission for this child to receive the chiropractic care that may be needed.

Consenting Adult's Signature

Parent SS#

Date

Witness Signature



Patient Birth Records Release

I, _____, Parent (or legal guardian) of the
below mentioned child, hereby authorize and direct _____

to release the records relating to the birth of (child's name)

_____,

To:

Chiropractic Works Health Center
1715 Howell Mill Road, C-12
Atlanta, GA 30318

Date of Birth: ____/____/____

May this signed consent form be your good authority to do so.

Parent/Guardian: (Printed) _____

Patient Signature: _____ **Date:**

Witness: _____

Thank You!