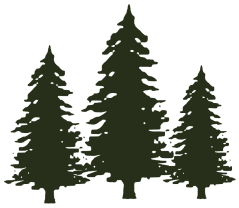

NORTHWOODS FAMILY CHIROPRACTIC

Initial Child & Adolescent Questionnaire

Your Name: _____, Your Parent: _____
Your Parent: _____

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? _____ Birth Center? _____
Obstetrician or Family MD?_____ Home? _____
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? _____

3. Tell us more:

Did you breastfeed? _____ How long? _____ What formula after? _____
Was breastfeeding difficult?_____
Did baby prefer one breast or did you change positions to accommodate?_____
Did baby have any latch issues or tongue or lip tie?_____
Revision performed? _____ Laser? _____ Any improvement? _____

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 "Jolly Jumper"
___ Frequent ear infections
___ Tonsillitis
___ 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 side" of this issue? **YES ___ NO ___**

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

___ Headaches
___ Dizziness
___ Ringing in ears
___ Arm/wrist pains
___ Numbness in arms/hands
___ Foot/ankle/knee pains
___ Tingling in arms/legs
___ Sleeping problems

___ Asthma

___ Hyperactivity

___ Fatigue

___ Neck/back pains

___ Allergies

___ Shoulder pains

___ Stomach problems

___ "Growing Pains"

___ 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 of 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? _____

_____

_____

_____

On a scale of 1 to 10, with 10 being the highest, rate your commitment in helping us solve this problem: _____

Signature of parent or guardian: _____Date: _____