Younis Chiropractic & Wellness Center

INITIAL CHILD & ADOLESCENT QUESTIONAIRE

Your name: _____

Mom's name: _____ **Dad's name:** _____

Mainly for Moms:

1. **Tell us about your pregnancy:**

   Did you carry to full term? _____

   Describe any complications during your pregnancy & when they occurred: _____

   _____

   _____

   Did you smoke during your pregnancy? _____ **Did you consume alcohol?** _____

   Did you have any ultrasound examinations? _____

2. **Tell us about delivery & birth:**

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

   Was your delivery At home_____ **Hospital** _____

   Did you have a C-Section _____

   Were forceps used? _____ **Vacuum extraction?** _____

   Were you induced? _____ **Did you have an epidural?** _____

   Would you say it was a difficult birth? _____

   What was your child's 1st APGAR Score? Score at 5 minutes? _____

3. **Tell us about your child's infancy:**

   Did you breast feed & for how long? _____

   Did you use formula? _____

   Did you consume alcohol? _____ **Did you smoke?** _____

   Did you take any medications? _____

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

___ Fall from a changing table
___ Tumble down stairs
___ Fall out of crib
___ Involved in a car accident
___ Falling of playground equipment
___ Playing in "Jolly jumper"
___ Frequent ear infections
___ Tonsillitis
___ Reaction to any vaccinations
___ Frequent crying spells
___ Frequent fevers
___ Frequent bouts of diarrhea
___ Constipation
___ Sleeping problems
___ Frequent colds
___ Colic
___ Did not gain weight
___ Torticollis\Rye neck
___Other _____

Please explain\elaborate on any of the above that you feel are important: _____

_____

_____

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

___ Diagnosis of Autism
___ Allergies
___ Seizures
___ Fall from a tree
___ Fall off a bike
___ Any sports injuries
___ Car accident
___ Scoliosis
___ Diagnosis of ADD or ADHD
___ Asthma
___ Learning disability_____
___ Bed wetting
___ Fall off playground equipment
___ Stomach pains
___ Knee\leg pains ("growing pains")
___ Other _____

Please explain\elaborate on any of the above that you feel are important: _____

_____

_____

6. What vaccines has your child had? _____

_____

_____

7. Did your child experience any adverse reactions to any of the vaccines? _____

_____

Were you told that you had a choice in whether or not to vaccinate your child Y N

8. As an adolescent, (12 to 18) has your child experienced any of the following:

___ Headaches
___ Dizziness
___ Ringing in ears
___ Back pain
___ Weight gain\loss
___ Numbness in arms\hands
___ Arm\wrist pain
___ Sleeping problems
___ Allergies
___ Knee\leg pains ("growing pains")
___ Foot\ankle\knee pain
___ Numbness in legs
___ Neck pain
___ Fatigue
___ Hyperactivity

Please explain\ elaborate on any of the above that you feel are important: _____

_____

_____

9. If you checked off multiple problems in sections 4, 5, or 8 please go back and circle the ones that are the worst.

10. For each of the conditions you marked, please reference them below and tell me what you have tried or done with regards to treatment that has NOT worked.

_____

_____

_____

_____

_____

_____

_____

_____

11. Has your child ever been hospitalized and for what? _____

_____

12. Is there anything else you feel you want me to know? _____

_____

_____

_____

_____

Signature of parent\guardian: _____

Date: _____