



Initial Child & Adolescent Questionnaire

Child's Name: _____ Mom: _____

Dad: _____ Date of Birth _____ Age _____

Today's Date _____

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? _____ 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? _____

3. Tell us more:

Did you breastfeed? _____ How long? _____ Which formula after? _____

Did you consume alcohol during your pregnancy? _____ Yes _____ No

Did you smoke? _____ Yes _____ No

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 a "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 more information on 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"/> Foot/ankle/knee pains |
| <input type="checkbox"/> Numbness in arms/hands | <input type="checkbox"/> Arm/wrist pains |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Tingling in arms/legs |
| <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Sleeping problems |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Neck/back pains |
| <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Shoulder pains |
| | <input type="checkbox"/> Stomach problems |
| | <input type="checkbox"/> "Growing Pains" |
| | <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. What have you done about it that has NOT worked? _____

11. What makes it worse? _____

12. What effect does this problem have of your child's daily activities?

13. Any hospital stays? _____ Reason? _____

14. Have antibiotics been prescribed? _____ How many times? _____

For what condition(s)? _____

15. Reason for this appointment? _____

16. Anything else we should know? _____

Thank You!

