Barrie Chiropractic & Health Services Centre
55 Cedar Pointe Dr. Unit 604 Barrie, ON L4N 5R7 705-792-6690
Cookstown Chiropractic
29 Queen Street Cookstown, ON L0L 1L0 705-458-8288
Dr. Darryl Bossence • Dr. Mark Trudeau

CHILD & ADOLESCENT HEALTH QUESTIONNAIRE

Name: _____ Mother's Name:_____

Father's Name:_____

Birthdate:_____ Age:_____

Mailing Address:_____City:_____Postal Code:_____

Home Phone:_____Parent Work Number:_____ Parent Cell Number:_____

Name of the person who referred you to this office:_____

Health Information regarding the Child

What is the reason for your visit with us today?_____

How long have you had this condition?_____

Have you had this or similar conditions in the past? _____

If yes, please explain:_____

What makes it feel better?_____

What aggravates the condition?_____

Is this condition getting progressively worse?_____

Have you had x-rays of your spine in the past year?_____ Have other Doctors treated this condition?_____

Tell us what has been done so far that has not worked? _____

_____

Have you ever suffered from: (check off all that apply)

Dizziness_____	Allergies_____	Diabetes_____	Headaches_____	Backaches_____
Heart Trouble_____	Asthma_____	Neck Pain_____	Digestive Disorders_____	
Sinus Trouble_____	Nervousness_____			

Tell us about Mom's pregnancy:
Did you carry full term?_____ How many previous pregnancies did Mom have?_____

Describe any complications and when they occurred:_____

_____

Name of child:_____

Tell us about the delivery and birth of this child:
Did you use a Midwife?_____ Did you deliver at a hospital?_____ Did you have an Obstetrician?_____
Did you have a C-Section?_____ Were forceps used? _____ Vacuum Extraction? _____
Were you induced?_____ Did you have an Epidural?_____ How long was labour?_____
What was the baby's APGAR score?_____

Tell us more:
Do/Did you breastfeed?_____ If yes, for how long?_____ Did you consume alcohol during your pregnancy? _____
Did you smoke?_____
Did you take any medications during your pregnancy? _____ For what?_____

_____ What type?_____
How many ultrasounds did you have during pregnancy?_____

Sleeping
Does the child fall asleep in less than 20 minutes?_____ more than 20 minutes?_____
How long does the child sleep at night? _____ hours. Naps? _____hours
Does the child cry less than 2 hours per day?_____ Does the child sleep on his/her back or belly or side?_____

Feeding
Does/did the child breastfeed? _____ How long after birth did the child feed/suck?_____hours/minutes
Is feeding messy? Describe the amount of "dribble" during feeding._____
Is "feeding" enjoyable for the child? _____ Is breastfeeding comfortable for Mom?_____
Would you say this child has a difficulty with sucking? _____

Elimination
How often are bowel movements per day?_____ How often does the child urinate per day?_____
Are bowel movements difficult for the child?_____ Is the child's stool soft or hard or liquid-like?_____
What is the colour of the stool?_____ Is the child gaining weight?_____
Is the child growing? _____ Is the child current with his/her vaccinations? _____

List any medications your child is currently taking:_____
_____

_____

List any allergies:_____

List any allergies of Mom, Dad or siblings:_____

_____

_____

_____ _____ _____
Name of Parent or Guardian Signature of Parent or Guardian Date