PELTIER FAMILY
CHIROPRACTIC & WELLNESS CENTER

Initial Child & Adolescent Questionnaire

Your Name: _____ Date: _____
First Name Nickname Middle Initial Last Name

Your Mom: _____ Your Dad: _____
(Include last names if it is not the same as yours)

Mainly for Moms:

1. Tell us about your pregnancy for this child:

Did you carry to full term? O Yes O No

Describe any complications and when they occurred: _____

2. Tell us about your delivery and birth of this child:

Did you use a midwife? O Yes O No Hospital? O Yes O No Obstetrician? O Yes O No
Did you have a C-Section? O Yes O No Were forceps used? O Yes O No
Vacuum Extraction? O Yes O No Were you induced? O Yes O No
Did you have an Epidural? O Yes O No Was it a difficult birth? O Yes O No

What was the baby's **APGAR** Score? _____ at 5 minutes? _____

3. Tell us more:

Did you breastfeed? O Yes O No How long? _____ What formula after? _____

Did you consume alcohol during your pregnancy? O Yes O No How much? _____

Did you smoke? O Yes O No How much? _____ How long? _____

Did you take any medication during your pregnancy? O Yes O No

For what? _____ What type? _____

Any exposures to ultrasound? O Yes O No 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
___ Tonsilitis
___ 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: _____

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? O YES O NO
Would you like information on the other side of this issue? O YES O NO

6. As a child or adolescent, has your child experienced any of the following:

___ Headaches
___ Dizziness
___ Ringing in ears
___ Asthma
___ Hyperactivity
___ Fatigue
___ Numbness in arms/hands
___ Arm/wrist pains
___ Sleeping problems
___ Allergies
___ Stomach problems
___ Weight gain/loss
___ Foot/ankle/knee pains
___ Tingling in arms/legs
___ Neck/back pains
___ Shoulder pains
___ Growing Pains
___ Other _____

Please explain any of the above: _____

7. **Which of the problems you have checked off is the worst?** _____

Is this problem: Constant _____ Intermittent _____ Occasional _____ Cyclic _____

8.. **How long has it persisted?** _____

9. **When it is at its worst, how does it make your child feel?** _____

10. **What have you done about it that has NOT worked?** _____

11. **What makes it worse?** _____

12. **What effect does this problem have on your child's body functions?** _____

13. **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?** _____

Printed Name of parent or guardian: _____

Signature of parent or guardian: _____ Date: _____