



Initial Child & Adolescent Questionnaire

Your Name: _____ Your Mom: _____

Your Dad: _____

Address: _____

City: _____ State: _____ Zip: _____

Home #: _____

SS#: _____ Sex: (Male/Female) Age: ____ DOB: _____

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? _____

3. Tell us more:

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

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 ___ Frequent crying spells

___ Tumble down stairs ___ Frequent fevers

___ Fall out of crib ___ Frequent bouts of diarrhea

___ Involved in car accident ___ Constipation

___ Fall off playground equipment ___ Sleeping problems

___ Play in a Jolly Jumper ___ Frequent colds

___ Frequent ear infections ___ Colic

___ Tonsillitis ___ Did not gain weight

___ Reaction to vaccination ___ Other _____

Please explain the above: _____

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

___ Fall from a tree ___ Bed wetting

___ Fall of a bicycle ___ Hyperactivity/Autism

___ Fall of playground equipment ___ Learning difficulties

___ Sports accident ___ Asthma

___ Car accident ___ Allergies

___ Stomach pains ___ Leg/knee pains

___ Scoliosis ___ 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 ___ Numbness in arms/hands ___ Foot/ankle/knee pains

___ Dizziness ___ Arm/wrist pains ___ Tingling in arms/legs

___ Ringing in ears ___ Sleeping problems ___ Neck/back pains

___ Asthma ___ Allergies ___ Shoulder pains

___ Hyperactivity ___ Stomach problems ___ Growing Pains@

___ Fatigue ___ 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/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? _____

Signature of parent or guardian: _____ **Date:** _____