Initial Child & Adolescent Questionnaire

Name: _____ Phone: _____
(Middle Initial)

Address: _____

City: _____ Postal Code: _____ Birth Date: _____
(Day / Month Year)

How did you hear about our clinic? _____

Medical Doctor: _____ Phone: _____

Your Child's Main Complaint: _____

Mom's Name: _____ Dad's Name: _____

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? _____ 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
- ☐ Tumble down stairs
- ☐ Fall out of crib
- ☐ Involved in a car accident
- ☐ Fall off playground equipment
- ☐ Play in a Jolly Jumper
- ☐ Frequent ear infections
- ☐ Tonsilitis
- ☐ 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:_____

_____

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_____

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 of your child's body functions? _____

_____

On his/her participation in daily activities? _____

13. Describe any hospital stays?_____

14. Approximately how many times have antibiotics been prescribed and for what conditions?

_____

15. List any medications your child is currently taking:_____

_____

16. To summarize, what is your purpose for this appointment? _____

_____

_____

17. Is there anything else you feel we should know? _____

_____

_____

_____

I know that the office has a privacy code and I can ask to see the code at any time.
I agree that Fairway Chiropractic Centre can collect, use and disclose personal information about me as set out in the office's privacy policy.

Signature of parent or guardian: _____

Date: _____

Fairway Chiropractic Centre
5 Manitou Dr. Unit #6, Kitchener, Ont. N2C 2J6
Ph (519) 748-5535, Fax (519) 748-5599
www.fairwaychiropractic.net