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## Initial Child & Adolescent Questionnaire

Your Name: \_\_\_\_\_, Your Mom: \_\_\_\_\_

Your Dad: \_\_\_\_\_

### 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?**

- |  |   |
|--|---|
| <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 of a bicycle            | <input type="checkbox"/> Hyperactivity/Autism  |
| <input type="checkbox"/> Fall of 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 information on the other side of 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"/> Numbness in arms/hands | <input type="checkbox"/> Foot/ankle/knee pains |
| <input type="checkbox"/> Dizziness       | <input type="checkbox"/> Arm/wrist pains        | <input type="checkbox"/> Tingling in arms/legs |
| <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Sleeping problems      | <input type="checkbox"/> Neck/back pains       |
| <input type="checkbox"/> Asthma          | <input type="checkbox"/> Allergies              | <input type="checkbox"/> Shoulder pains        |
| <input type="checkbox"/> Hyperactivity   | <input type="checkbox"/> Stomach problems       | <input type="checkbox"/> Growing Pains®        |
| <input type="checkbox"/> Fatigue         | <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. 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?  
\_\_\_\_\_  
\_\_\_\_\_
- 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? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signature of parent or guardian: \_\_\_\_\_

Date: \_\_\_\_\_

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