



## Initial Child & Adolescent Questionnaire

Today's Date: \_\_\_\_\_  
 Child's Name: \_\_\_\_\_ Mom's name: \_\_\_\_\_  
 Dad's name: \_\_\_\_\_  
 Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zipcode \_\_\_\_\_  
 Home phone: \_\_\_\_\_ Alternate phone: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Social Security#: \_\_\_\_\_  
 Parent's email address: \_\_\_\_\_  
**What is the purpose for this appointment?** \_\_\_\_\_

### 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? \_\_\_\_\_  
 List medications: \_\_\_\_\_  
 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             |



**5. continued – as a young child, did any of the following occur?**

- Stomach pains
- Scoliosis
- Leg/knee pains
- Other \_\_\_\_\_

Please explain the above: \_\_\_\_\_  
\_\_\_\_\_

**6. Tell us about any vaccinations your child has had:** \_\_\_\_\_  
\_\_\_\_\_

Did you have a reaction to any of these? \_\_\_\_\_

Were you told that you had a choice in vaccinating your child?  **YES**,  **NO**

**7 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: \_\_\_\_\_  
\_\_\_\_\_

**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. How do these problems affect your child's quality of life?**  
\_\_\_\_\_  
\_\_\_\_\_

**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. Is there anything else you feel we should know?** \_\_\_\_\_  
\_\_\_\_\_

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