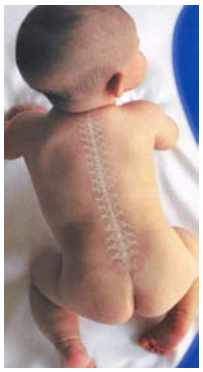

Inside Out Family Chiropractic

Our mission is to help as many people as possible achieve and maintain their optimum health potential, especially children

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Patient Introduction

Personal History:

Patient Name:_____
First Middle Last

Your Address: _____

_____

_____

Telephone: Res:_____ **Bus:**_____ **Email:** _____

Health Card: _____ (Please bring health card to front desk)

Birth Date: Day: _____ **Month:** _____ **Year:** _____

Marital Status:_____

Occupation: _____

Employer: _____

Previous Chiropractor: _____ **City:** _____

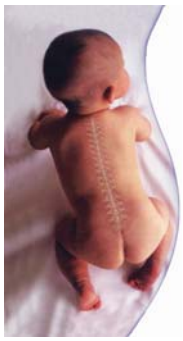
Last visit to this Chiropractor:_____

Reason for leaving: _____

_____

Present MD: _____ **City:** _____

Referred to our Centre by:_____



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Child & Adolescent Health Questionnaire

Your Name: _____ Your Mom: _____

Your Dad: _____

This Part Is Mainly for Moms:

1. Tell us about your pregnancy;

Did you carry to full term? _____ If not, how many weeks gestation? _____

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 1 minute? _____/10 & at 5 minutes? _____/10

Was there initial respiratory delay? _____ Purple markings on face? _____

Mis-shaped skull/head? _____

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? _____

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 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: _____

_____

_____

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**

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 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)**

Thank You!