First Step Family Chiropractic

910 Dundas Street West. Whitby, ON L1P 1P7 Tel: (905) 665-9599 Fax: (905) 665-9699 Pt#
Dr. Kristen Ruttan & Dr. Ellen Chin

Initial Child & Adolescent Questionnaire

Name: _____
Mom: _____
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?

___ 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
___ Tonsillitis
___ 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: _____
_____

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

___ Fall from a tree
___ Fall of a bicycle
___ Fall of 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**
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
___ Foot/ankle/knee pains
___ Arm/wrist pains
___ Ringing in ears
___ Neck/back pains
___ Allergies
___ Hyperactivity
___ Growing Pains
___ Weight gain/loss
___ Numbness in arms/hands
___ Dizziness
___ Tingling in arms/legs
___ Sleeping problems
___ Asthma
___ Shoulder pains
___ Stomach problems
___ Fatigue
___ 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? _____

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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: _____