Cartagine Chiropractic

and Wellness

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?

___ Fall from changing 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: _____
_____
_____

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: _____
_____
_____

Are you aware of 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
___ Dizziness
___ Numbness in arms/hands
___ Arm/wrist pains
___ Foot/ankle/knee pains
___ Tingling in arms/legs

___ Ringing in ears ___ Sleeping problems ___ Neck/back pains
___ Asthma ___ Allergies ___ Shoulder pains
___ Hyperactivity ___ Stomach problems ___ Growing Pains
___ Fatigue ___ Weight gain/loss ___ 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 on 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 or vitamins 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? _____
_____
_____
_____

I hereby authorize Dr. Rosemarie Cartagine to examine and/or treat my child.

Signature of parent or guardian: _____

Date: _____

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