



Belleville Chiropractic and Wellness Center
1019 River St. Suite 5 Belleville, WI 53508
(608)424-1840

Initial Child & Adolescent Questionnaire (5-12 years)

Your Name: _____, Your Mom: _____
Your Dad: _____

Prenatal History:

1. Tell us about your pregnancy;

Did you carry to full term?

Yes

No

Describe any complications and when they occurred: _____

Did you consume alcohol/smoke during your pregnancy?

Yes

No

Did you take any medication during your pregnancy?

Yes

No

Did you have any ultrasound during pregnancy?

Yes

No

Birth History:

2. Tell us about your delivery and birth of this child:

Did you use a midwife?

Yes No

Did you have a C-Section?

Yes No

Birth Trauma?

Doctor assisted

Vacuum Extraction

Forceps

Was labor induced?

Yes No

Did you have an Epidural?

Yes No

Was it a difficult birth?

Yes No

APGAR Score:

at birth ___/10

at 5 minutes ___/10

3. Tell us more:

Did you breastfeed? Yes No If yes, for how long? _____

If any, what formula did you use after?

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

- | | |
|--|--|
| <input type="checkbox"/> Fall from tree | <input type="checkbox"/> Bed wetting |
| <input type="checkbox"/> Fall off a bicycle | <input type="checkbox"/> Hyperactivity/autism |
| <input type="checkbox"/> Fall off playground equipment | <input type="checkbox"/> Learning difficulties |
| <input type="checkbox"/> Sports accident | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Stomach pains | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Leg pains |
| <input type="checkbox"/> Other_____ | |

Please explain the above: _____

5. Tell us about any vaccinations your child has had: _____

Were there any negative 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

6. As a child or adolescent, has your child experienced any of the following:

- | | | |
|---|--|--|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Sleeping problems | <input type="checkbox"/> Tingling in arms/legs |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Allergies | <input type="checkbox"/> Neck/back pains |
| <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Stomach problems | <input type="checkbox"/> Shoulder pains |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Weight gain/loss | <input type="checkbox"/> Growing pains |
| <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> Foot/ankle pains | <input type="checkbox"/> Other_____ |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Knee pains | |
| <input type="checkbox"/> Numbness in arms/hands | | |
| <input type="checkbox"/> Arm/wrist pain | | |

Please explain any of the above: _____

7. Which of the problems above bothers your child the most? _____

8. When did it begin?_____ Is it getting worse?_____

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 much does the complaint affect daily activities/routines?

14. Which sports does your child play?

- | | |
|--|--------------------------------------|
| <input type="checkbox"/> Basketball | <input type="checkbox"/> Hockey |
| <input type="checkbox"/> Dance | <input type="checkbox"/> Swimming |
| <input type="checkbox"/> Wrestling | <input type="checkbox"/> Tennis |
| <input type="checkbox"/> Baseball/softball | <input type="checkbox"/> Gymnastics |
| <input type="checkbox"/> Soccer | <input type="checkbox"/> Lacrosse |
| <input type="checkbox"/> Football | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Volleyball | |

15. Describe any hospital stays: _____

16. Approximately how many times have antibiotics been prescribed and for
What conditions? _____

17. List any medications your child is currently taking: _____

18. To summarize, what is your purpose for this appointment? _____

19. Is there anything else you feel we should know? _____

Signature of parent or guardian: _____

Date: _____