Listro Chiropractic Clinic

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:_____

Your address: _____
_____
_____

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

Health Card: _____

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

Previous Chiropractor: _____ **City:** _____

Last visit to the chiropractor: _____

Reason for leaving: _____
_____

Present MD: _____ **City:** _____

Referred to our centre by: _____

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 is 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? _____

   Di you take any medication during your pregnancy? _____

   Any exposure to ultrasound? _____ How many? _____

4. **As a baby/ toddler, (birth to 4 years), did any of the following occur?**

_____ Fall from a change table	_____ Frequent crying spells
_____ Tumble down stairs	_____ Frequent fevers
_____ Fall out of crib	_____ Frequent bouts of diarrhea
_____ Involved in car accident	_____ Constipation

_____ Play in "Jolly Jumper"
_____ Fall off playground equipment
_____ Frequent ear infections
_____ Tonsillitis
_____ Reaction to vaccination
_____ 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 from 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 is about any vaccinations your child has had:

_____
_____

Any 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 the ears
_____ Asthma
_____ Hyperactivity
_____ Fatigue
____ Numbness in arms/hands
____ Arm/wrist pain
____ Sleeping Problems
____ Stomach problems
____ Allergies
____ Weight gain/loss
____ Foot/ankle/knee pains
____Tingling in the 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 worst?** _____

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!