Initial Child & Adolescent Questionnaire

Name: _____ Phone: _____
(Middle Initial)

Address: _____

City: _____ Postal Code: _____ Birth Date: _____
(Day / Month Year)

How did you hear about our clinic? _____

Medical Doctor: _____ Phone: _____

Your Child's Main Complaint: _____

Mom's Name: _____ Dad's Name: _____

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 a car accident
- ☐ Fall off playground equipment
- ☐ Play in a Jolly Jumper
- ☐ Frequent ear infections
- ☐ Tonsilitis
- ☐ 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. 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_____

7. Which of the problems you have checked off is the worst _____

Is this problem: Constant ◯, Intermittent ◯, Occasional ◯, Cyclic ◉

8. How long has it persisted?_____

9. When it is at its worst, how does it make your child feel? _____

10. What have you done about it that has NOT worked? _____

_____

11. What makes it worse? _____

12. What effect does this problem have of your child's body functions? _____

_____

On his/her participation in daily activities? _____

13. Describe any hospital stays?_____

14. Approximately how many times have antibiotics been prescribed and for what conditions?

_____

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

_____

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

_____

_____

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

_____

_____

_____

I know that the office has a privacy code and I can ask to see the code at any time.
I agree that Fairway Chiropractic Centre can collect, use and disclose personal information about me as set out in the office's privacy policy.

Signature of parent or guardian: _____

Date: _____

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Fairway Chiropractic Centre 519-748-5535

Your Informed Consent

Although Chiropractic is reported to be the safest health care system in the world, some say there are very slight risks associated with it. We feel that it is responsible to let you know:

a. Risk of stroke is reported to be 1 in 5-8 million or so... and the cause has yet to be determined.
b. While extremely rare, there have been reports of ligament sprains, and even rib fractures reported.
c. There have been rare reports of disc injuries although no clinical scientific study has ever demonstrated chiropractic care to be the cause.

Chiropractic care has been proven to be both, clinically and very cost effective. The risk of injuries and complications is so small that chiropractors carry the lowest malpractice insurance premiums of all the health care professions in the world.
Compared to traditional medical/drug/surgical care, which has a yearly death rate of approximately 200,000 people in North America, Chiropractic is your safest health care system.

I have read and understand the above consent, and have had the opportunity to discuss it with my chiropractor.
I consent to the care recommended by my chiropractor and extend this consent to include all doctors of this Chiropractic & Wellness Centre. This consent applies to all present and future care for me and my family.

Your Name: _____, Date: _____

Your Signature: _____

Witness: _____