



Date \_\_\_/\_\_\_/\_\_\_

Note: Please answer all questions. If it does not apply, please write **n/a** (for not applicable).

-Thank you!

### *Initial Child & Adolescent Questionn*

Child's name: \_\_\_\_\_ Age: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Parents/ guardian name(s): Mom: \_\_\_\_\_ Dad: \_\_\_\_\_

Guardian: \_\_\_\_\_ Relationship: \_\_\_\_\_

### *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? \_\_\_\_\_ and at 5 minutes? \_\_\_\_\_

If your child was adopted, please include any relevant information here: \_\_\_\_\_  
\_\_\_\_\_

#### **3. We would also like to know:**

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? Y N . . .

For what? \_\_\_\_\_ What type? \_\_\_\_\_

Any exposures to ultrasound? \_\_\_\_\_, How many? \_\_\_\_\_

### *About your Child*

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

- |                                                        |                                                     |
|--------------------------------------------------------|-----------------------------------------------------|
| <input type="checkbox"/> Fall from a change table      | <input type="checkbox"/> Frequent crying spells     |
| <input type="checkbox"/> Tumble down stairs            | <input type="checkbox"/> Frequent fevers            |
| <input type="checkbox"/> Fall out of crib              | <input type="checkbox"/> Frequent bouts of diarrhea |
| <input type="checkbox"/> Involved in car accident      | <input type="checkbox"/> Constipation               |
| <input type="checkbox"/> Fall off playground equipment | <input type="checkbox"/> Sleeping problems          |
| <input type="checkbox"/> Play in Jolly Jumper          | <input type="checkbox"/> Frequent colds             |
| <input type="checkbox"/> Frequent ear infections       | <input type="checkbox"/> Colic                      |
| <input type="checkbox"/> Tonsillitis                   | <input type="checkbox"/> Did not gain weight        |
| <input type="checkbox"/> Reaction to vaccination       | <input type="checkbox"/> Illness: _____             |
| <input type="checkbox"/> Other: _____                  |                                                     |

**Please explain the above:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

- |                                                        |                                                |
|--------------------------------------------------------|------------------------------------------------|
| <input type="checkbox"/> Fall from a 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"/> Car accident                  | <input type="checkbox"/> Allergies             |
| <input type="checkbox"/> Stomach pains                 | <input type="checkbox"/> Leg/knee pains        |
| <input type="checkbox"/> Scoliosis                     | <input type="checkbox"/> Illness _____         |
| <input type="checkbox"/> Other: _____                  |                                                |

**Please explain the above:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

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

**Please explain any of the above:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**7. Has your child had any vaccinations? If yes, tell us about them.**

\_\_\_\_\_  
\_\_\_\_\_

**Any vaccine reactions** noted after receiving them? Y N . If yes, **please note** which vaccine and what you noticed after it was given. \_\_\_\_\_  
\_\_\_\_\_

Were you told that you had a choice in vaccinating your child? \_\_\_YES \_\_\_NO  
(If you would like more information about this topic, just visit our web site and enter "vaccination" in our article search feature.)

**8. Which of the current problems you've checked off are of the greatest concern**

to you and/or your child? Why?

\_\_\_\_\_

**Is this problem:** Constant \_\_, Intermittent \_\_, Occasional \_\_, Cyclical \_\_

9. When did it start? \_\_\_\_\_
10. What makes this problem worse? \_\_\_\_\_  
\_\_\_\_\_
11. What have you tried so far **that has NOT** worked with this problem?  
\_\_\_\_\_
12. Does it affect their participation in daily activities? Y N. If yes, how?  
\_\_\_\_\_
13. How does your child's behavior/ disposition change when it's at its worst?  
\_\_\_\_\_
14. Has your child ever been hospitalized and if so, why? \_\_\_\_\_  
\_\_\_\_\_
15. Approximately how many times have antibiotics been prescribed and for what conditions?  
\_\_\_\_\_
16. List any medications your child is currently taking & for what reason(s):  
\_\_\_\_\_
17. Has your child been in any vehicle accidents? Details: \_\_\_\_\_  
Any surgery? Details: \_\_\_\_\_  
Any fractured/broken bone(s): Details: \_\_\_\_\_
18. In closing, what is your main reason for this appointment ?
- Chiropractic spinal evaluation & assessment
  - learn more about Chiropractic's drug-free, non-surgical approach to improving my family's health and quality of life.
  - Other: \_\_\_\_\_

I, the undersigned, give Dr. Schneider and his staff permission to evaluate my child or children. If treatment is provided, it is because it has been authorized by me.

Signature(parent or guardian): \_\_\_\_\_

Relationship to child: father mother guardian\_\_\_\_\_