Belleville Chiropractic and Wellness Center
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CHILD QUESTIONARE (5-12 YEARS)

Child's name: _____ Parent: _____

Parent: _____

Prenatal History

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

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 [ ]

Was labor induced? Yes [ ] No [ ]

Did you have an epidural? Yes [ ] No [ ]

Was it a difficult birth? Yes [ ] No [ ]

Birth trauma? Doctor assisted [ ] Vacuum extraction [ ] Forceps [ ]

APGAR score: at birth ____/10 at 5 minutes ____/10

Tell us more:

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

If any, what formula did you use after? _____

As a baby/toddler, did any of the following occur?

- o Fall from a tree
- o Hyperactivity/Autism
- o Sports accident
- o Allergies
- o Bed wetting
- o Fall off playground equipment
- o Asthma
- o Scoliosis
- o Fall off a bicycle
- o Learning difficulties
- o Stomach pains
- o Leg pains

Other: _____

Please explain the above: _____

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 the information on the other side of this issue? Yes [ ] No [ ]

As a child/adolescent, has your child experienced any of the following?

- o Headaches
- o Stomach problems
- o Tingling in arms/legs
- o Arm/hand numbness
- o Knee Pains
- o Sleeping problems
- o Neck/back pains
- o Asthma
- o Foot/ankle pains
- o Fatigue
- o Shoulder pains
- o Ringing in ears
- o Weight gain/loss
- o Growing pains
- o Other _____
- o Dizziness
- o Allergies
- o Growing pains
- o Arm/wrist pain

Please explain any of the above: _____

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

When did it begin? _____ **Is it getting worse?** _____

Is this problem: Constant [ ] Intermittent [ ] Occasional [ ] Cyclic [ ]

How long has it persisted? _____

When it is as its worst, how does it make your child feel? _____

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

What makes it worse? _____

How much does the complaint affect daily activities/routines? ___

_____

Which sports does your child play?

- ○ Basketball
- ○ Swimming
- ○ Baseball/softball
- ○ Football
- ○ Hockey
- ○ Wrestling
- ○ Gymnastics
- ○ Volleyball
- ○ Dance
- ○ Tennis
- ○ Soccer
- ○ Other: _____

Describe any hospital stays: _____

_____

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

_____

List any medications your child is currently taking: _____

_____

To summarize, what is your purpose of this appointment? _____

_____

Is there anything else you feel we should know? _____

_____

Signature of parent/guardian: _____ Date: _____