

Infant, Child & Adolescent Health Survey & Questionnaire

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

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:

	Y or N			Y or N
Did you use a midwife?	_____	Vacuum Extraction?		_____
Hospital?	_____	Were you induced?		_____
Obstetrician?	_____	Did you have an Epidural?		_____
Did you have a C-Section?	_____	Was it a difficult birth?		_____
Were forceps used?	_____	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(s)? _____

Any exposures to ultrasound? _____ How many? _____

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"/> Sleeping problems
<input type="checkbox"/> Frequent crying spells	<input type="checkbox"/> Play in A Jolly Jumper @ _____ mos/yrs
<input type="checkbox"/> Tumble down stairs	<input type="checkbox"/> Frequent colds
<input type="checkbox"/> Frequent fevers	<input type="checkbox"/> Frequent ear infections
<input type="checkbox"/> Fall out of crib	<input type="checkbox"/> Colic
<input type="checkbox"/> Frequent bouts of diarrhea	<input type="checkbox"/> Tonsillitis
<input type="checkbox"/> Involved in car accident	<input type="checkbox"/> Did not gain weight
<input type="checkbox"/> Constipation	<input type="checkbox"/> Reaction to vaccination
<input type="checkbox"/> Fall off playground equipment	<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"/> Asthma |
| <input type="checkbox"/> Bed wetting | <input type="checkbox"/> Car accident |
| <input type="checkbox"/> Fall of a bicycle | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Hyperactivity/Autism | <input type="checkbox"/> Stomach pains |
| <input type="checkbox"/> Fall of playground equipment | <input type="checkbox"/> Leg/knee pains |
| <input type="checkbox"/> Learning difficulties | <input type="checkbox"/> Scoliosis |
| <input type="checkbox"/> Sports accident | <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"/> Other _____ |

Please explain any of the above: _____

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 on your child's body functions?

On his/her participation in daily activities? _____

13. Describe any hospital stays: _____

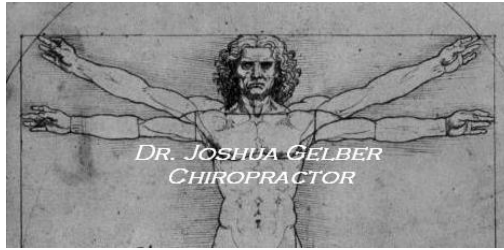
14. Approximately how many times have antibiotics been prescribed and for what conditions?

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? _____

Signature of parent or guardian: _____ Date: _____



TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective. Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be able to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation (Nervous System Traffic Jam): A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential. We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal evaluation, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **OUR ONLY PRACTICE OBJECTIVE** is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, _____ have read and fully understand the above statements.

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

(Signature)

(Date)