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Kids First

My mission is to help as many people in my lifetime as I can – especially children! Dr. John Ferguson

Child & Adolescent Questionnaire

Your Name: ______________________________ Birth Date:______________ Today's Date:______________

Your address:_____________________________ City:_______________ Zip:_______ Phone:_______________

Your Mom: _________________________ Your Dad: ______________________ Gender: ❍Male ❍Female

Email address (for Monthly Newsletter/updates): ____________________________________

Would you like information on a specific topic? _______________________________

Insurance Carrier:______________________ Policy Number:____________________

Have you consulted a Chiropractor before? ❍Yes ❍No When?___________ If so, whom?________________

Reason for leaving: ____

Spinal X-Rays taken in the last 12 months? ❍YES ❍NO Body Part(s)______________________________

Any other previous imaging studies (CT scan, MRI, etc.) ❍YES ❍NO Body Part(s)______________________

Present MD/DO: _______________________________ Address: ________________________________

Phone: _________________________________

Who may we thank for referring you into our office?____

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 (0-10)? ___________ 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 car accident
___ Fall off playground equipment
___ Play in a Jolly Jumper
___ Frequent ear infections
___ Tonsilitis
___ Reaction to vaccination
___ 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. Tell us about any vaccinations your child has had: _______________

____

Any reactions to any of these? ____

Were you told that you had a choice in vaccinating your child? ___**YES** ___**NO**

Would you like information on the other side of this issue? ___**YES** ___**NO**

7. 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 ________________

Please explain any of 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 worse?** ____

13. **What effect does this problem have on your child's body functions**?

____

14. **On his/her participation in daily activities?** __________________________

15. **Describe any hospital stays:** _______________________________________

____

16. **Approximately how many times have antibiotics been prescribed and for what conditions?** ____

17. **List any medications your child is currently taking:** ____________________

____

18. **To summarize, what is your purpose for this appointment?** ____________

____

19. **Is there anything else you feel we should know?** _____________________

____

20. **If we were able to find the cause of your child's problem and get rid of it, please rate your level of commitment in helping us do this (on a scale of 1 to 10, with 10 being the highest):** ___________

Acknowledgements:

To set clear expectations, improve communications and help you get the best results in the appropriate amount of time, please read each statement and initial agreement.

Initials ______ I instruct the chiropractor to deliver the care that, in his or her professional judgment, can best help me in the restoration of my child's health. My child may be adjusted in a semi-private room where private information I offer may be overheard by others. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct spinal misalignments/nerve stress (vertebral subluxations). Chiropractic is a separate healing art from medicine and does not proclaim to cure any named disease or entity.

Initials ______ I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved parties.

Initials ______ I realize that an x-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge my child is not pregnant. Date of last menstrual period (MM/DD/YY):______________

Initials ______ I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of my care in this office.

Initials______ I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.

Initials ______ To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my child's health concern(s).

Signature of parent or guardian: ____________________________ **Date:** ______________________