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

Kids First

Ferguson Family Chiropractic, PLLC
Family Care · Sports · Children · Wellness
653 Plank Road
Clifton Park, NY 12065
518.383.5595
www.ForLifetimeWellness.com

Child & Adolescent Questionnaire

Child's Name: _____ Birth Date:_____ Gender: ❍Male ❍Female

Today's Date:_____ Home Phone:_____

Your address:_____ City:_____ Zip:_____

Your Mom(s):_____ Phone #: _____ E-mail: _____

Your Dad(s): _____ Phone #: _____ E-mail: _____

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 (this helps the Doctor determine any potential physical, chemical or emotional stresses to the child that can affect spine and nerve system development):

1. Tell us about your pregnancy:

Any trouble conceiving?_____ 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? _____ At Hospital, home or other? _____ 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 birth? _____ at 5 minutes? _____

3. Tell us more:

Did you breastfeed? _____ How long? _____ What formula after? _____
Did you consume alcohol during your pregnancy? _____ How much/often? _____
Did you smoke? _____ How much? _____ How long? _____
Did you take any medication during your pregnancy?_____For what?_____
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/crib
___ Trouble latching on/feeding
___ Did not crawl/walk on time
___ Involved in car accident
___ Fall off playground equipment
___ Play in a Jolly Jumper
___ Ear infections or Tonsillitis
___ Carried in baby carrier
___ Reaction to vaccination
___ Frequent crying spells
___ Frequent fevers
___ Frequent diarrhea/constipation/reflux/colic
___ Did not make appropriate eye contact
___ Sleeping problems
___ Frequent colds
___ Dragged leg when crawling
___ Walk on toes or with foot turned in
___ Other_____

Please explain the above:
_____

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

___ Fall from over 2 feet
___ Fall off a bicycle
___ Fall off playground equipment
___ Sports accident
___ Car accident
___ Stomach pains
___ Scoliosis
___ Bed wetting
___ Hyperactivity
___ Learning difficulties
___ Asthma
___ Allergies
___ Hip/Leg/knee pains
___ Distracted when reading

Please explain the above or other concerns: _____
_____

Is your child's Vaccination schedule: normal or altered?
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 natural immune development? ___**YES** ___**NO**

Would you like information on vaccines from the "other side" of the issue? ___**YES** ___**NO**

6. As a child or adolescent, has your child experienced:

___ Numbness in arms/hands	___ Foot/ankle/knee pains
___ Shoulder/Arm/wrist pains	___ Tingling in arms/legs
___ Sleeping problems	___ Neck/back pains
___ Allergies	___ Headaches/Migraines
___ Stomach problems	___ Growing Pains
___ Weight gain/loss	___ Other _____

Please explain the above or other concerns: _____
_____

7. Describe any hospital stays: _____

_____

8. Approximately how many times have antibiotics been prescribed_____

and for what conditions? _____

9. List any medications or supplements your child is currently taking:

_____

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 female child is not pregnant. Date of last menstrual period (__/__/____)

Initials _____ I grant permission to be called. texted and/or e-mailed to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information 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:** _____

Thank you for your trust!