Initial Child & Adolescent Questionnaire

Lakeville Chiropractic

Name _____ Age ____ Date of Birth ____/____/____

Address _____ City _____ Zip _____

Mother: _____ Father: _____

Contact Information: E-mail _____

Home Phone_____ Cell Phone _____

Grade: _____ Sports and hobbies: _____

How did you hear about us? Who may we thank for referring you? _____

Current pediatrician: _____ City: _____

Have you or your child ever received chiropractic care? __Y __N Name of D.C._____

Last visit to this chiropractor: _____

Reason for Leaving: _____

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? _____ 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? _____ Did you take any medication during your pregnancy? _____

For what? _____ What type? _____

Any ultrasounds? _____ 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 "Jolly Jumper"
___ Frequent ear infections
___ "Growing Pains"
___ 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 of a bicycle
___ Fall of playground equipment
___ Sports accident
___ Car accident
___ Stomach pains
___ Scoliosis
___ Bed wetting
___ Hyperactivity/Autism
___ Learning difficulties
___ Asthma
___ Allergies
___ "Growing Pains"
___ Other_____

Please explain the above: _____
_____

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 above 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 of your child's body functions? _____
_____

On his/her participation in daily activities? _____

14. Describe any hospital stays: _____
_____

15. Approximately how many times have antibiotics been prescribed, and for what conditions? ____
_____

16. List any medications your child is currently taking: _____
_____

17. To summarize, what is your purpose for this appointment? _____
_____
_____

18. Is there anything else you feel we should know? _____
_____
_____

The information I have provided on this form, is true and accurate to the best of my knowledge. I give Dr. Michael P. Griffin permission to render care today. This initial visit includes a health history/consultation, chiropractic exam/evaluation. I also give my consent to have the doctor order any x-rays that he deems appropriate, and any initial care that is determined to be clinically necessary and mutually agreed upon.

Signature of Parent (for minor): _____ Today's Date_____

"My mission is to help as many people in my lifetime as possible, especially children."

-Michael Griffin, DC

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Electronic Health Records Intake Form

In compliance with requirements for the government EHR program

First Name:_____ **Last Name**:_____

Email address: _____@_____

Preferred method of communication for patient reminders (Circle one): Email / Text Message

DOB: __/__/____ **Gender (Circle one):** Male / Female **Language:** _____

☐ **Smoking Status (Circle one):** Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

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Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) Native Hawaiian or Pacific Islander / Other / I Decline to Answer

☐ **Ethnicity (Circle one):** Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Any current medications? (Please include regularly used over the counter medications)

☐

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Any *medication* allergies? ___ No ___Yes

☐

Medication Name	Reaction	Onset Date	Additional Comments

☐ **I choose to decline receipt of my child's clinical summary after every visit** *(These summaries are often blank as a result of the nature and frequency of chiropractic care.)*

Parent's Signature: _____ Date:_____

☐

Office Use Only

Height: _____ Weight:_____ Blood Pressure:_____ /_____