Back To Health Chiropractic Centre – 20 Cranston Park Ave, #6, Maple, ON L6A 2W2 – Dr. Walter Salubro

Child & Adolescent Health Questionnaire

Today's Date	Patient #

Name (Last, First)		Birth date (month/day/year)	Sex ❒ Male ❒ Female
Address	Apt #	City	Province
Postal Code	Home Phone	Mom's Name	Mom's Cell Phone
Who may we thank for referring you to this office?		Dad's Name	Dad's Cell Phone
Name of emergency contact		Relationship to you	Emergency Phone Contact

Did you find us on the Internet? If yes, how?
□ Google □ Yahoo □ Bing □ Our Website □ Other What keywords did you search with:

_____

☐**Yes! I would like to receive BTHCC's e-mail newsletter for notices on workshops, events and wellness tips.**

Print first & last name: **Print e-mail address clearly:**

CONSULTATION / HISTORY REVIEW

Vertebral Subluxation Interview

Are you aware that every symptom or condition is typically the result of interference of your nervous system or from subluxation (spinal misalignment)? **Y** _____ **N** _____

Symptoms and pain are the two most common results of Subluxation. Symptoms and pain are usually signals to let your body know something is wrong.

1. What is the main health problem you would like checked today? _____
Is this the first time or have you experienced this problem in the past?_____

2. If there is pain, does your pain ever radiate into your arms or legs or is it local in one area?
ARM R L LEGS R L NO, IT STAYS IN ONE AREA (Circle one).

3. How long has this condition been a problem? _____

4. Subluxations can cause different irritation / sensation to the nerve fibers. Describe how your pain feels.
Check all that apply to you. ____ **Sharp** ____ **Dull** ____**Achy** ____ **Burning** ____ **Tingling** ____ **Numbness**

5. How severe is your pain on a scale of 1 – 10, where 10 is the worse pain: no pain 0 1 2 3 4 5 6 7 8 9 10 worse pain

6. How many times did you experience this problem during the week: 1x 2x 3x 4x 5x 6x every day

7. Subluxations often put pressure on the spinal cord. Symptoms may come and go over time. Is your condition
CONSTANT OR INTERMITTENT (Comes and Goes) (Circle one).

8. Pressure on the spinal cord may vary during the day. Is your condition worse in the: **AM or PM (Circle one).**

9. Have you done anything to relieve your pain and suffering? _____

10. Is there anything else you think the doctor should know concerning your condition? YES _____ or NO _____
If yes, please describe: _____

11. Is your injury due to an accident, injury or trauma? Y _____ N _____ If so, was it AUTO _____ or OTHER _____
Describe the events of the accident: _____

_____

12. Have you seen any other health care providers for this accident, injury or trauma? Y _____ N _____ Who? _____
What treatment did you receive? _____

13. Who is your child's family doctor / pediatrician? **Doctor's Name** _____ **Tel:** _____

Last Visit Date: _____

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SOCIAL HISTORY

1. Compare this problem at its worst and when your child is doing great. How does this problem interfere with:
   a. Your child's ability to do school work? _____
   b. Your child's ability to enjoy family time? _____
   c. Your child's ability to enjoy play time? _____
   d. Your child's ability to enjoy hobbies or sports? _____

FAMILY HEALTH HISTORY

1. Do any member of your family suffer from the same condition? YES ____ NO ____ Whom? _____

2. Is there a history of any of the following conditions in your child's immediate family (mom, dad, grandparents and siblings)?

Heart disease: YES ____ NO ____ Whom? _____
Stroke: YES ____ NO ____ Whom? _____
Cancer: YES ____ NO ____ Whom? _____
Diabetes: YES ____ NO ____ Whom? _____

This Part Is Mainly For Moms:

1. Tell us about your pregnancy:

Did you carry to full term? _____ If not, how many weeks gestation? _____

Describe any complications and when they occurred: _____

2. Tell us about your delivery and birth of this child: _____

Did you use a midwife? **Yes** or **No** Doula: **Yes** or **No** Hospital? **Yes** or **No** Obstetrician? **Yes** or **No** Home Birth? **Yes** or **No**

Did you have a C-Section? **Yes** or **No** Were forceps used? **Yes** or **No** Vacuum Extraction? **Yes** or **No**

Were you induced? **Yes** or **No** Did you have an Epidural? **Yes** or **No** Was it a difficult birth? **Yes** or **No** Complications? _____

What was the baby's APGAR Score at 1 minute? _____/10 & at 5 minutes?_____/10 Was there initial respiratory delay? **Yes** or **No**

Birth Weight _____ Birth Length _____

3. Growth & Development

Was the infant alert and responsive within 12 hours of delivery? **Yes** or **No** If no, explain: _____

At what age did your child: Respond to sound? _____ Follow an object? _____ Hold up head? _____ Vocalize? _____

Sit alone? _____ Teethe? _____ Crawl? _____ Walk? _____

Do his / her sleeping patterns seem normal? **Yes** or **No**

The following information is very important because many of the problems that chiropractors work with are caused by stressors.

4. Chemical Stressors

Did you consume alcohol during pregnancy? **Yes** or **No** How much? _____

Did you smoke? **Yes** or **No** How much? _____ How long? _____

Did you take any medication during your pregnancy? _____

Received ultrasounds? **Yes** or **No** How many? _____ Receive invasive procedures (ie amniocentesis, CVS)? **Y es** or **No**

Did your child receive vaccinations? **Yes** or **No** If yes, which ones? _____ Any reactions to them? **Yes** or **No**

Has your child had antibiotics? **Yes** or **No** If yes, how many courses has the child had so far and why? _____

Any pets at home? **Yes** or **No** Any smokers at home? **Yes** or **No** If yes, how much? _____

Did you breastfeed? **Yes** or **No** How long? _____ At what age was: 1a. Formula introduced _____ 1b. Brand _____

5. Psychological Stressors

Any difficulties with lactation? **Yes** or **No** Any problems bonding? **Yes** or **No** Does your child seem normal to you? **Yes** or **No**

Does your child have any behavioural problems? **Yes** or **No** If yes, what? _____

Does your child have difficulty sleeping (eg. night terrors, sleepwalking, etc.) **Yes** or **No** If yes, specify: _____

Did your child go to daycare? **Yes** or **No** From what age? _____ yrs. Avg no of hours of TV / computer / video games per week? _____

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6. **Traumatic Stressors**

Any evidence of trauma during birth? ☐ bruises ☐ mis-shaped skull ☐ stuck in birth canal ☐ excessively long birth ☐ cord around neck

Any falls during pregnancy? **Yes** or **No** Does your child play sports? **Yes** or **No** Number hours / week? _____ What age began? _____

Weight of school backpack? (circle) **Light** or **Moderate** or **Very Heavy** Approx. spent at play per week? _____ hrs

7. As a baby/toddler, (birth to 4 years), did any of the following occur to your child?

____ 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
____ 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: _____

8. 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: _____

9. 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 the above: _____

10. Describe any hospital stays: _____

11. Describe any surgeries: _____

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

13. To summarize, what is your goal / objective for this appointment?

_____

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

Thank you for your input. This information will be very beneficial in helping the doctor to understand your child's health history, while being very respectful of your time. We look forward to helping you and your family.

Print Your Child's Name: _____

Name of Parent or Guardian: _____

Date: _____ _____