



# Child and Adolescent Health Questionnaire

*This part is mainly for Moms:*

## 1. Tell us about your pregnancy:

Did you carry full term? \_\_\_\_\_ If not, how many weeks gestation? \_\_\_\_\_

Describe any complications that occurred: \_\_\_\_\_

\_\_\_\_\_

## 2. Tell us about your delivery and birth of your 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? \_\_\_\_\_

Were any drugs given to mom or baby during or after delivery? \_\_\_\_\_

What was the baby's **APGAR** score at 1 minute? \_\_\_\_\_ /10 at 5 minutes \_\_\_\_\_ /10

Was there initial respiratory delay? \_\_\_\_\_ Purple markings on face or neck? \_\_\_\_\_

Misshapen head or skull? \_\_\_\_\_

## 3. Tell us More:

Did you breastfeed? \_\_\_\_\_ For how long? \_\_\_\_\_ What formula after? \_\_\_\_\_

Did you consume alcohol, cigarettes, medications or other drugs during your pregnancy?

\_\_\_\_\_ How Much \_\_\_\_\_ How Long? \_\_\_\_\_

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

**7. 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 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 you 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? \_\_\_\_\_

\_\_\_\_\_  
(Signature of Parent or Guardian)

\_\_\_\_\_  
(Date)

**Thank You!**