



Humfeld Family Chiropractic, P.C.

119 Central Ave. Faribault, MN 55021 Phone (507) 333-5388

Child & Adolescent Health Questionnaire

Your name: _____ Your Mom: _____ Your Dad: _____
Address: _____ Phone: _____ Age: ____ DOB: _____

Mainly For Parents:

1. Tell us about your pregnancy: Did you carry 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 were 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 _____
Did you consume alcohol during your pregnancy? _____ How much? _____
Did you smoke? _____ How much? _____ How long? _____
Did you take any medications during your pregnancy? _____
For what? _____ What type? _____
Any exposure to ultrasound? _____ How many? _____

4. As a baby/toddler (birth to 4) did any of the following occur?

___ Fall from a changing table ___ Frequent crying spells ___ Frequent ear aches
___ Tumble down stairs ___ Frequent fevers ___ Tonsilitis
___ Fall out of crib ___ Frequent bouts of diarrhea ___ Reactions to shots
___ Involved in a car accident ___ Constipation ___ Did not gain weight
___ Play in a "Jolly Jumper" ___ Sleeping problems ___ Colic
___ other

Please explain the above: _____

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

___ Fall from a tree ___ Sports accident ___ Bedwetting ___ Asthma ___ Scoliosis
___ Fall from a bicycle ___ Stomach pain ___ Car accident ___ Fall off playground equipment
___ Hyperactivity/Autism ___ Allergies ___ Learning disabilities ___ Leg/Knee pain
___ Other

Please explain: _____

6. Tell us about any vaccinations your child has had: _____

Any reactions to any of these? _____

Were you given a choice in vaccinating your child? _____

Would you like information on the "other side" of the issue? _____

7. Has your child experienced any of the following?

Headaches Numbness in arms/hands Foot/ankle/knee pain
 Dizziness Arm/wrist pain Tingling in the arms/legs

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 function? _____

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)

(Date)