# Initial Child & Adolescent Questionnaire

Child's Name: _____ Mom's Name: _____
Date of Birth: _____ Dad's Name: _____
Social Security: _____ Phone: _____

Address: _____
E-mail_____

Insurance Company: _____
Insurance ID & Group #: _____

Pediatrician: _____
Address:_____
I authorize Dr. Gabaldon to contact my child's pediatrician_____

**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?_____

**3. Tell us more:**

Did you breastfeed? _____ How long? _____
Did you take any medication during your pregnancy? _____
For what? _____What type_____
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 | ___ | Frequent crying spells |
| ___ | Tumble down stairs | ___ | Frequent fevers |
| ___ | Fall out of crib | ___ | Frequent bouts of diarrhea |
| ___ | Involved in car accident | ___ | Constipation |
| ___ | Fall off playground equipment | ___ | Sleeping problems |
| ___ | Play in Jolly Jumper | ___ | Frequent colds |
| ___ | Frequent ear infections | ___ | Colic |
| ___ | Tonsillitis | ___ | Did not gain weight |
| ___ | Reaction to vaccination | ___ | Other_____ |

Please explain the above:

_____

_____

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

| | | | |
|---|---|---|---|
| ___ | Fall from a tree | ___ | Bed wetting |
| ___ | Fall of a bicycle | ___ | Hyperactivity/Autism |
| ___ | Fall of playground equipment | ___ | Learning difficulties |
| ___ | Sports accident | ___ | Asthma |
| ___ | Car accident | ___ | Allergies |
| ___ | Stomach pains | ___ | Leg/knee pains |
| ___ | Scoliosis | ___ | 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

Would you like information on the other side of this issue? ___YES ___NO

7. As a child or adolescent, has your child experienced any of the following:

| | | |
|---|---|---|
| ___ Headaches | ___ Numbness in arms/hands | ___ Foot/ankle/knee pains |
| ___ Dizziness | ___ Arm/wrist pains | ___ Tingling in arms/legs |
| ___ Ringing in ears | ___ Sleeping problems | ___ Neck/back pains |
| ___ Asthma | ___ Allergies | ___ Shoulder pains |
| ___ Hyperactivity | ___ Stomach problems | ___ Growing Pains |
| ___ Fatigue | ___ Weight gain/loss | ___ Other _____ |

Please explain any of 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. What have you done about it that has NOT worked? _____

_____

_____

11. Describe any hospital stays: _____

_____

12. Approximately how many times have antibiotics been prescribed and for what conditions? _____

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

_____

14. How often does your child get exercise?_____

15. Does your child get the daily recommended 5-9 servings of fruits/vegetables?_____

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

_____

_____

_____

Dr. Gabaldon recommends babies get adjusted 4 times during the first year (in addition to any trauma). These visits coincide with the following milestones: birth, teething, crawling, and walking (approximately).

Older children should also be adjusted 4 times per year (minimum) up to once per month for optimal neurological function.

_____ Please remind me of baby/child's quarterly recommended adjustment via :

TEXT PHONE CALL EMAIL STANDARD MAIL

_____ Please do NOT remind me of baby/child's quarterly recommended adjustment.

Signature of parent or guardian: _____

Date: _____


## Consent to Treatment of a Minor Child

I hereby authorize Dr. Cynthia Gabaldon and whomever she may designate as her assistants to administer treatment as she so deems necessary to my child,

_____

(name of child)

Dated in Orlando, Florida this _____ day of _____, 20____.

Signed: _____

Name (printed): _____

Witness: _____


# Photograph Release Form

As an educational means (to share with other chiropractors and birth professionals) we like to share pictures of different procedures performed at our office. This has been a valuable tool for other parents and healthcare providers to see and learn from what we do. We do not use identifying criteria. Feel free to go on Gabaldon Family Chiropractic Facebook page for examples of chiropractic photo albums. If the persons are tagged, it is because the PATIENT has gone on the page and tagged him or herself to share the pictures with friends and family.

Please initial and sign below:

_____ **YES**, I authorize Gabaldon Chiropractic to take pictures of my family and release to publications and advertisements to include but not limited to networking websites (i.e. Facebook), for the publicity of the office and/or its special events.

_____ **NO**, I do not authorize Gabaldon Chiropractic to take pictures of my family and release to publications and advertisements to include but not limited to networking websites (i.e. Facebook), for the publicity of the office and/or its special events.

_____ _____ _____

Patient's Name (Printed) Signature (or guardian) Date