Infant – Toddler Health Questionnaire (0 – 3)

Infant – Toddler Information.

First Name: _____ Last Name: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Date of Birth: D_____ M_____ Y_____ Age: _____

Gender: ☐ Female ☐ Male

Family Physician _____ Date of last visit: _____

Pediatrician: _____Date of last visit: _____

Health Card Number: _____

Parent/Guardian Contact Information

Parent/ Guardian Name: _____

Phone Number: _____

Email Address: _____

How did you hear about our office: ☐ Website ☐ Internet ☐ Drive by ☐ Referral: _____

Chiropractic Experience

Has your child ever been to a chiropractor before? ☐ Yes ☐ No

If yes, Name _____ Where_____

Reason for visit: _____ Approximated date of last visit: _____

Was your child adjusted: ☐ No ☐ Yes

Medication

Number of doses of antibiotics child has taken:

During the last 6 months: _____

Total during lifetime: ☐ None ☐ 1-5 ☐ 6-10 ☐ More

Number of doses of other prescribed medications child has taken during his/her lifetime:

☐ None ☐ 1-5 ☐ 6-10 ☐ More than 10

Please list all medications: _____

Current Health Condition

Describe the reason for today's visit: ☐ Spinal evaluation ☐ Specific health condition ☐ Wellness/Prevention ☐ Early detection

☐ Maximizing growth and development. ☐ Other _____

Describe the specific health condition: _____

When did this condition begin? _____ ☐ Suddenly or ☐ Gradually

Has this condition occurred before: ☐ No ☐ Yes When? _____

Does this condition radiate: ☐ No ☐ Yes
If yes, where? _____

What makes it worse? _____

What makes it better? _____

Does this condition interfere with your child's: Sleep ☐ No ☐ Yes Eating ☐ No ☐ Yes Daily Routine ☐ No ☐ Yes

Is this condition getting worse: ☐ No ☐ Yes
What other professionals have you consulted for this condition? _____

Treatment received: _____

Results: ☐ Good ☐ Fair ☐ Poor
Recent Medical Tests done (list dates beside)

☐ Blood work _____ ☐ Urine Analysis _____ ☐ X-rays _____ ☐ Other _____

Pre Natal and Birth History (Mother and Child)

Name of Obstetrician and/or Midwife: _____

Duration of gestation: _____ weeks Duration of labor: _____ hours

Location of birth ☐ Home ☐ Birthing center ☐ Hospital

Any traumas (falls, accidents) during pregnancy ☐ No ☐ Yes
If yes, describe: _____

Any illness(es) during pregnancy ☐ No ☐ Yes
If yes, describe: _____
During pregnancy, did you

Take supplements ☐ No ☐ Yes Type: _____

Take medication ☐ No ☐ Yes Type: _____

Have any ultrasound ☐ No ☐ Yes Number _____

Use alcohol ☐ No ☐ Yes Use tobacco/drugs ☐ No ☐ Yes

Describe your Delivery

Any complications during delivery ☐ No ☐ Yes
If yes, describe: _____

Assisted ☐ No ☐ Yes ☐ Forceps ☐ Vacuum extractor ☐ C-section ☐ Induced labor ☐ Epidural

Was intensive care required ☐ No ☐ Yes
If yes, describe: _____

Any Genetic disorder or disability ☐ No ☐ Yes
If yes, describe: _____

Any evidence of birth trauma ☐ Bruising ☐ Odd shape head ☐ Stuck in birth canal ☐ Respiratory problems ☐ Cord around neck

Was your child alert and responsive with 12 hours of birth ☐ No ☐ Yes
Infant birth weight _____ Infant birth length _____

Feeding History

Breastfed ☐ No ☐ Yes If yes how long; _____

Formula fed ☐ No ☐ Yes Type; _____ When was it introduced? _____

At what age did you introduce:

Cow's Milk: _____

Solid Food: _____ Types: _____

Food and/or Milk intolerance/allergies ☐ No ☐ Yes

If yes, describe: _____

Child's Health History

Please check each of the diseases or conditions that your child has now or has had in the past.

☐ Vision changes	☐ Headaches	☐ Frequent Colds	☐ Allergies	☐ Asthma
☐ Sleeping problems	☐ Bed wetting	☐ Colic	☐ Irritability	☐ Skin problems
☐ Hyperactivity	☐ Urinary problems	☐ Digestive problems	☐ Bloating/Gas	☐ Loss of concentration
☐ Ear pain/infections	☐ Frequent crying	☐ Sore throat	☐ Breathing problems	☐ Fainting
☐ Fatigue	☐ Loss of balance	☐ Upper back pain	☐ Poor coordination	☐ Constipation
☐ Pneumonia	☐ Neck Pain	☐ Seizure	☐ Bronchitis	
☐ Lower back pain	☐ Other _____			

Developmental History

Has your child fallen from bed, changed table, couch, stairs? ☐ No ☐ Yes

If yes, explain: _____

Has your child ever been involved in a car accident? ☐ No ☐ Yes

Describe: _____

Has your child ever been hospitalized? ☐ No ☐ Yes

Describe: _____

Has your child ever been seen on an emergency basis? ☐ No ☐ Yes

Describe: _____

Did your child ever have major surgery? ☐ No ☐ Yes

Describe: _____

INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE FOR MINOR

I hereby request and consent to the performance of chiropractic examination, adjustment, and other chiropractic procedures, including various modes of physical therapy and if necessary, diagnostic x -rays, on my child by the Doctor of Chiropractic and/or anyone working in this clinic authorized by the Doctor of Chiropractic.

I have had an opportunity to discuss with the Doctor of Chiropractic and/or with other office or clinic personnel, the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I further understand and am informed that, as in all health care, in the practice of chiropractic there are some very slight risks to treatment, including, but not limited to, muscle strains and sprains, disc injuries, and strokes. I do not expect the doctor to be able to anticipate and explain all risks and complications and I wish to rely on the doctor to exercise judgement during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interest.

I have read the above and consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above name procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

_____ _____

Name of child receiving care Parent or guardian authorizing care