Cookstown Chiropractic & Wellness Centre
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Dr. Mark Trudeau Dr. Jordan Winberg

INFANT & TODDLER HEALTH HISTORY INTAKE QUESTIONNAIRE

Name: ____________________________ Male/ Female DOB: ______________________ Age: ______________
Mom: ____ Dad: ____
Mailing Address: ____ City: ________________________
Postal Code: ________________ Home Phone: ______________________ Alternate: _________________
Name of the person who referred you to our office: ____

HEALTH INFORMATION

What is the reason for your visit with us today? ____
____
____
How long have you had this condition? ____
____
Have you had this, or similar conditions in the past? ____
____
What makes it feel better? ____
____
What aggravates this condition? ____
____
Is this condition getting progressively worse? ____
____
Have you had x-rays of your spine in the last year? ____
Other doctors or health care practitioners who have treated this condition: __________________________
____
Height: _______ Weight: ___________ Activity Level: None Low Moderate High

HAS THE CHILD EVER SUFFERED FROM?

	Y	N		Y	N		Y	N
Dizziness			Diabetes			Headaches		
Backaches			Asthma			Neck Pain		
Digestive Disorders			Nervousness			Sinus Trouble		
Allergies			Heart Trouble					

TELL US ABOUT MOM'S PREGNANCY

Did you carry to full term? Yes No
How many previous pregnancies did Mom have? _____________
Please describe any complications, and when they occurred: ______________________________________
____
____
____
____

TELL US ABOUT THE BIRTH & DELIVERY OF THIS CHILD

	Y	N		Y	N		Y	N
Did you use a midwife?			Hospital?			Vacuum Extraction?		
Did you have a C-Section?			Were forceps used?			Did you have an epidural?		
Were you induced?			Obstetrician?					
How long was labour?				What was the baby's APGAR Score?				

TELL US MORE:
Did/ do you breastfeed? Yes No If so, for how long? ___________________________
Did you consume alcohol during your pregnancy? Yes No
Did you take any medications during your pregnancy? Yes No For what? ___________________________
What type(s)? ___________________________
How many ultrasounds did you have during your pregnancy? ___________________________

SLEEPING
Does the child fall asleep in less than 20 minutes? Yes No More than 20 minutes? Yes No
How long does the child sleep at night? ___________________________
The child sleeps on their: Back Belly Side Naps ___________________________ hours
Does the child cry less than 2 hours per day? Yes No

FEEDING
Does/did the child breastfeed? Yes No
How long after birth did the child feed/suck? ___________________________ (hours/minutes)
Is feeding messy? Describe the amount of 'dribble' during feeding: ___________________________
Is 'feeding' enjoyable for the child? Yes No
Is breastfeeding comfortable for mom? Yes No
Would you say this child has difficulty sucking? Yes No

ELIMINATION
How often are bowel movements per day? ___________________________ Are bowel movements difficult? Yes / No
How often does the child urinate per day? ___________________________
The child's stool is: Soft Liquid Hard Stool Colour: ___________________________
Is the child gaining weight? Yes No Is the child growing? Yes No
Has, or will, the child be vaccinated? Yes No
List any medications this child is currently taking: ___________________________
____
List any allergies: ___________________________
List any allergies of Mom, Dad or Siblings: ___________________________
____

Additional Comments: ___________________________
____
____
____
____

Name of Parent or Guardian (Please Print): ___________________________
Signature of Parent or Guardian: ___________________________

Date: ___________________________