



Toddler Health Questionnaire (13-36 mo)

Insurance Information:

Personal Information:

Date: _____

Child's Name: _____

Child's Address: _____

City: _____ State: _____ Zip: _____

Birth date: _____ Age: _____ Gender: M F

Soc. Sec #: _____

Child's Home Phone No. () _____

Mother's Name: _____

Mother's Cell Phone No. () _____

Mother's E-mail: _____

Mother's Employer: _____

Work Phone: () _____ Ext: _____

Father's Name: _____

Father's Cell Phone No. () _____

Father's E-mail: _____

Work Phone: () _____ Ext: _____

Number of Siblings: _____ Ages: _____

Referred By: _____

Interested in appointment reminders? Email Text

Do you expect insurance to contribute to your child's care? Yes No

Insured's Name: _____ DOB: _____

Relationship to Child: _____ Effective Date: _____

Insurance Company: _____

ID or Contract Number: _____

Group or FECA Number: _____

Phone Number: () _____ Ext: _____

Adjuster or Contact Name: _____

Claims Address: _____

City: _____ State: _____ Zip: _____

Lifestyle Information:

How would you rate your toddler's ability to play or exert themselves physically without known limitations or restrictions?

Excellent Very Good Good Average Poor

How do you rate your toddler's diet and quality of food intake?

Excellent Very Good Good Average Poor

How do you rate your awareness and effort to avoid environmental chemicals and toxins for your toddler?

Excellent Very Good Good Average Poor

How do you rate your toddler's ability to handle psychological and emotional stressors?

Excellent Very Good Good Average Poor

On a scale (1 worst, 10 best) how would you rank your toddler's overall health & wellness status?

1 2 3 4 5 6 7 8 9 10

On a scale (1 least, 10 most) how would you rank your priority for your toddler's health?

1 2 3 4 5 6 7 8 9 10

Emergency Contact:

Name: _____

Relationship to Child: _____

Phone: () _____ Home Cell

Office Phone: () _____ Ext: _____

Pediatrician/PCP's Name: _____

Subluxation Related Complaints:

The goal of your toddler's chiropractic evaluation is to identify neurological stress and abnormal neuro-structural patterns called spinal subluxations. Although chiropractic care is not a treatment for any specific medical condition it is common for spinal subluxations to be directly or indirectly related to many of the following toddler related conditions. Please check if your child has any of the following:

- | | |
|--|---|
| <input type="radio"/> Asymmetrical Facial Features | <input type="radio"/> Difficulty Nursing / Eating |
| <input type="radio"/> Neck Pain / Back Pain / Growing Pains | <input type="radio"/> Back Arching / Tension |
| <input type="radio"/> Head Tilt / Torticollis | <input type="radio"/> Autism Spectrum Disorders / Neuro-Sensory Dysfunction |
| <input type="radio"/> Head Distortion/ Plagiocephaly | <input type="radio"/> Seizures / Neurological Ticks |
| <input type="radio"/> Ear Aches / Ear Infections | <input type="radio"/> Appears Clumsy / Poor Coordination |
| <input type="radio"/> Behavior Concerns/ Frequent Tantrums | <input type="radio"/> Abnormal Sleep Patterns |
| <input type="radio"/> GERD / Acid Reflux | <input type="radio"/> Skin Problem / Rash / Eczema |
| <input type="radio"/> Constipation / Diarrhea / Digestive Issues | <input type="radio"/> Allergies / Intolerances to Foods or Formula |

General Health:

Diet History:

Was/is your child breast fed? Exclusively Breastfed Previously Breastfed Breastfed and Formula Fed

Formula Details (if Applicable): Milk Soy Organic Homemade Special: _____

Supplements your child takes directly: _____

Supplements mom takes if nursing: _____

Vaccinations History: Up-to-Date Partial Delaying Conscientious Objector Concerned/Unknown

Vaccine Reactions: _____

Pregnancy History:

Please provide us with information as it relates to your pregnancy with this child by checking all that apply:

- | | | |
|---|--|---|
| <input type="radio"/> Accident While Pregnant | <input type="radio"/> Group-B Strep Positive | <input type="radio"/> Pre-Eclampsia |
| <input type="radio"/> Alcohol Consumption | <input type="radio"/> Hypertension | <input type="radio"/> Prescription Medication |
| <input type="radio"/> Amniocentesis | <input type="radio"/> Bacterial or Viral Infection | <input type="radio"/> Radiation Exposure |
| <input type="radio"/> Abnormal Fetal Position or Breech | <input type="radio"/> Yeast/Fungal Infection | <input type="radio"/> Recreational Drug Use |
| <input type="radio"/> Chemical Exposure | <input type="radio"/> Morning Sickness / Nausea | <input type="radio"/> Rhogam Injection |
| <input type="radio"/> Frequent Ultrasounds: # _____ | <input type="radio"/> Placenta Abruptio | <input type="radio"/> Swelling or Edema |
| <input type="radio"/> Genetic Testing | <input type="radio"/> Placenta Previa | <input type="radio"/> Pre-Natal Vitamins |
| <input type="radio"/> Gestational Diabetes | <input type="radio"/> Poor Nutrition | <input type="radio"/> Unknown/Adopted |

Birth & Labor History:

Birth Weight: _____ Place of Birth: Hospital Birthing Center Home

Birth Height: _____ Birth Care Providers: OB/Gyn Midwife Doula

Final APGAR: _____

Please check all that apply in regards to your labor and the birth process for this child:

- | | | |
|---|---|---|
| <input type="radio"/> Fetal Monitoring | <input type="radio"/> Long and/or Difficult Labor | <input type="radio"/> Fetal Distress |
| <input type="radio"/> Abnormal or Breech Presentation | <input type="radio"/> Antibiotics Administered | <input type="radio"/> Meconium |
| <input type="radio"/> Cord Around Neck | <input type="radio"/> Pain Medication | <input type="radio"/> Forceps |
| <input type="radio"/> Labor Induced | <input type="radio"/> Epidural | <input type="radio"/> Suction Device |
| <input type="radio"/> Rupture of Membranes | <input type="radio"/> Lack of Fetal Decent | <input type="radio"/> Obstetrical Pulling |
| <input type="radio"/> Pitocin Administered | <input type="radio"/> Lack of Progression | <input type="radio"/> Cesarean Section |

Post Natal History:

Choose all that apply for your child as a newborn:

- | | |
|--|---|
| <input type="radio"/> Resuscitation/Oxygen Required | <input type="radio"/> Premature |
| <input type="radio"/> Prolonged Cranial Distortion | <input type="radio"/> Poor Sleeping |
| <input type="radio"/> Difficulty Nursing/Latching/Suckling | <input type="radio"/> Jaundice |
| <input type="radio"/> Meconium Aspiration/Stomach Pumped | <input type="radio"/> Low APGAR score |
| <input type="radio"/> Antibiotic Administered | <input type="radio"/> Failure to Thrive |
| <input type="radio"/> Circumcised | <input type="radio"/> Colic |

Family History:

- Arthritis
- Cancer
- Cardiovascular/ Heart Disease
- Diabetes
- Hypertension
- Genetic Disorder
- Unknown/ Adopted

Please write your toddler's age in months: _____. Then answer only the following questions as it pertains to your toddler's current age:

13 - 20 months old:

Question:	Yes	Sometimes	Not Yet
1a. Does your toddler tell you what they want by pointing to it?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
1b. Does your toddler imitate 2 word sentences (ie: mamma go)?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
1c. Does your toddler correctly point to a picture of something when asked to identify it?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2a. Does your toddler try to help undress themselves?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2b. Does your toddler attempt to get your attention by pulling at you or your arm?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2c. Can your toddler lift, drink and put down a cup of water without spilling much?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3a. Can your toddler stand by his/herself in the middle of the floor and take a few steps?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3b. Does your toddler walk well by themselves and move around by walking more than crawling?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3c. Does your toddler attempt to kick a ball?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4a. Can your toddler pick up a very small object with the tips of their fingers and thumb?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4b. Does your toddler play by stacking small blocks on one another?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4c. Can your toddler turn the pages of a book all by themselves?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

21 - 28 months old:

Question:	Yes	Sometimes	Not Yet
1a. Does your toddler correctly point to a picture of something when asked to identify it?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
1b. Can your toddler verbally identify a common object that you point to?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
1c. Can your toddler identify and point to a few of their own body parts?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2a. Can your toddler lift, drink and put down a cup of water without spilling much?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2b. Does your toddler successfully eat with a fork?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2c. Does your toddler use pronouns such as "I" or "me"?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3a. Does your toddler attempt to kick a ball?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3b. Can your child walk up and down a few stairs?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3c. Can your toddler jump by leaving the floor with both feet at the same time?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4a. Can your toddler turn the pages of a book all by themselves?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4b. Does your child turn light switches on and off?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4c. Can your toddler string small beads or such on to a string?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

29 - 36 months old:

Question:	Yes	Sometimes	Not Yet
1a. Does your toddler use 3-4 word sentences?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
1b. Does your toddler understand the concepts of up and down?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
1c. When asked "what is your name?" does your toddler answer with both their first and last names?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2a. Does your toddler use a spoon to eat without spilling much?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2b. Can your toddler put on a shirt or coat by themselves?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2c. Does your toddler wait in line for their turn?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3a. Can your toddler jump forward a few inches with both feet?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3b. Can your toddler stand by themselves on one leg for at least 1 second?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3c. Does your toddler attempt to throw a ball overhand?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4a. Can your toddler string small beads or such on to a string?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4b. Does your toddler attempt to cut paper with child-safe scissors?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4c. Does your toddler hold a pencil or crayon between their thumb and fingers similar to an adult?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Infant Health History (ROS):

Constitutional:

- Fever
- Headache
- Recent Trauma
- Pain Complaints
- Fatigue
- Poor Sleep
- Loss of Appetite
- Weight Loss

EENT:

- Excessive Tearing
- Blocked Tear Duct
- Eye Infections
- Poor Eye Control
- Poor Hearing
- Ear Aches/Infection
- Discharge from Ear
- Poor Smell
- Nasal Congestion
- Difficulty Swallowing
- Difficult Speech
- Spots on Tongue
- Tongue Tied
- Tooth Decay

Respiratory:

- Difficulty Breathing
- Shortness of Breath
- Asthma / Wheeze
- Sputum
- Chronic Cough

Genital:

- Undescended Testes
- Hydrocele
- Testicular Torsion
- Gonadal Mass
- Genital Rash
- Vaginal Discharge
- Yeast Infections
- Breast Mass

Integumentary:

- Jaundice
- Skin Rash / Hives
- Eczema
- Bruises
- Scars
- Skin Masses/Bumps
- Skin Color Changes

Musculoskeletal:

- Swelling of Muscles/Joints
- Limited Range of Motion
- Fall from a High Surface

Neurological:

- Seizures Convulsions
- Neurological Ticks
- Lightheaded/Dizziness
- Tremors
- Clumsy/Poor Balance

Cardiovascular:

- Poor Circulation
- Chest Pain
- Extremity Swelling
- Abnormal Heart Rhythm

Immunological:

- Food Intolerance
- Environmental Intolerance
- Allergy
- Lymph Node Enlargement
- Meningitis
- Serious Infection

Gastrointestinal:

- Bloating
- Constipation
- Diarrhea
- Stomach Tenderness
- Stomach Aches
- Vomiting
- Lack of Appetite
- Bloody Stools
- Dark Tarry Stools
- Itchy Bottom

Endocrine:

- Neck or Thyroid Mass
- Abnormal Growth Patterns
- Excessive Sweating

Urinary:

- Difficult Urination
- Foul Smelling Urine
- Blood in Urine
- Seemingly Painful Urination
- Kidney Problems

Medical History

Please list any **Prescription Medications** your child takes:

Please list any **Surgical Procedures** your child has had:

Has your child ever needed any **Emergency Services**?

List any known **Allergies** that your child currently has:

Minor Consent

Consent for Evaluation and Treatment of a Minor Child:

I hereby authorize the Doctor to treat my child's conditions as he/she deems appropriate through the use of chiropractic adjustments and related services. Furthermore, the Doctor will not be held responsible for any pre-existing medically diagnosed conditions, nor for any medical diagnosis.

"I hereby authorize the Doctor and whomever he/she may designate as his/her associate to administer chiropractic care as he/she deems necessary to my child"

Child's Name: _____

Parent/Guardian Name: _____

 Guardian Signature: _____

Date: _____