# Toddler Health Questionnaire (13-36 mo)

## 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?* O Email O Text

## Emergency Contact:

Name: _____

Relationship to Child: _____

Phone: (  ) _____ O Home O Cell

Office Phone: (  ) _____ Ext: _____

Pediatrician/PCP's Name: _____

## Insurance Information:

*Do you expect insurance to contribute to your child's care?* O Yes O 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?*

O Excellent O Very Good O Good O Average O Poor

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

O Excellent O Very Good O Good O Average O Poor

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

O Excellent O Very Good O Good O Average O Poor

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

O Excellent O Very Good O Good O Average O Poor

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

O 1 O 2 O 3 O 4 O 5 O 6 O 7 O 8 O 9 O 10

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

O 1 O 2 O 3 O 4 O 5 O 6 O 7 O 8 O 9 O 10

## 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:*

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

Child's Name: _____ Date: _____

## General Health:

**Diet History:**

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

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

Supplements your child takes directly: _____

Supplements mom takes if nursing: _____

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

O Vaccine Reactions: _____

## Pregnancy History:

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

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

## Birth & Labor History:

Birth Weight: _____

Birth Height: _____

Final APGAR: _____

*Place of Birth:* O Hospital O Birthing Center O Home

*Birth Care Providers*: O OB/Gyn O Midwife O Doula

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

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

## Post Natal History:

*Choose all that apply for your child as a newborn:*

- O Resuscitation/Oxygen Required
- O Prolonged Cranial Distortion
- O Difficulty Nursing/Latching/Suckling
- O Meconium Aspiration/Stomach Pumped
- O Antibiotic Administered
- O Circumcised
- O Premature
- O Poor Sleeping
- O Jaundice
- O Low APGAR score
- O Failure to Thrive
- O Colic

## Family History:

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

## Developmental & Neurosensory

Child's Name: _____ Date: _____

*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? | O | O | O |
| 1b. Does your toddler imitate 2 word sentences (ie: mamma go)? | O | O | O |
| 1c. Does your toddler correctly point to a picture of something when asked to identify it? | O | O | O |
| 2a. Does your toddler try to help undress themselves? | O | O | O |
| 2b. Does your toddler attempt to get your attention by pulling at you or your arm? | O | O | O |
| 2c. Can your toddler lift, drink and put down a cup of water without spilling much? | O | O | O |
| 3a. Can your toddler stand by his/herself in the middle of the floor and take a few steps? | O | O | O |
| 3b. Does your toddler walk well by themselves and move around by walking more than crawling? | O | O | O |
| 3c. Does your toddler attempt to kick a ball? | O | O | O |
| 4a. Can your toddler pick up a very small object with the tips of their fingers and thumb? | O | O | O |
| 4b. Does your toddler play by stacking small blocks on one another? | O | O | O |
| 4c. Can your toddler turn the pages of a book all by themselves? | O | O | O |

### 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? | O | O | O |
| 1b. Can your toddler verbally identify a common object that you point to? | O | O | O |
| 1c. Can your toddler identify and point to a few of their own body parts? | O | O | O |
| 2a. Can your toddler lift, drink and put down a cup of water without spilling much? | O | O | O |
| 2b. Does your toddler successfully eat with a fork? | O | O | O |
| 2c. Does your toddler use pronouns such as "I" or "me"? | O | O | O |
| 3a. Does your toddler attempt to kick a ball? | O | O | O |
| 3b. Can your child walk up and down a few stairs? | O | O | O |
| 3c. Can your toddler jump by leaving the floor with both feet at the same time?\ | O | O | O |
| 4a. Can your toddler turn the pages of a book all by themselves? | O | O | O |
| 4b. Does your child turn light switches on and off? | O | O | O |
| 4c. Can your toddler string small beads or such on to a string? | O | O | O |

### 29 - 36 months old:

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

## Infant Health History (ROS):

Child's Name: _____ Date: _____

**Constitutional:**
- O Fever
- O Headache
- O Recent Trauma
- O Pain Complaints
- O Fatigue
- O Poor Sleep
- O Loss of Appetite
- O Weight Loss

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

**Respiratory:**
- O Difficulty Breathing
- O Shortness of Breath
- O Asthma / Wheeze
- O Sputum
- O Chronic Cough

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

**Integumentary:**
- O Jaundice
- O Skin Rash / Hives
- O Eczema
- O Bruises
- O Scars
- O Skin Masses/Bumps
- O Skin Color Changes

**Musculoskeletal:**
- O Swelling of Muscles/Joints
- O Limited Range of Motion
- O Fall from a High Surface

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

**Cardiovascular:**
- O Poor Circulation
- O Chest Pain
- O Extremity Swelling
- O Abnormal Heart Rhythm

**Immunological:**
- O Food Intolerance
- O Environmental Intolerance
- O Allergy
- O Lymph Node Enlargement
- O Meningitis
- O Serious Infection

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

**Endocrine:**
- O Neck or Thyroid Mass
- O Abnormal Growth Patterns
- O Excessive Sweating

**Urinary:**
- O Difficult Urination
- O Foul Smelling Urine
- O Blood in Urine
- O Seemingly Painful Urination
- O 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:** _____