Encinitas Chiropractic
BLENDING BODY, MIND & SPIRIT

Toddler/Young Child Health History

Patient Information

First name: _____ Last Name: _____ Date: _____

Address: _____ City: _____ State: _____

Zip Code: _____ Date of Birth: _____ Height: _____ Weight: _____

Parent/Guardian Name: _____ Relationship: _____

Primary Phone (Cell/Home/Work): _____ Email: _____

Presenting condition & History:

Please describe your child's current conditions (i.e. reflux, not sleeping/eating well, gas, etc…): _____

_____

Is your child suffering or suffered from: Fevers Rashes Seizures NICU stay NONE

Breast Fed: Yes No Duration: _____ Formula Fed: Yes No Duration: _____

Type of formula: Lactose Soy Amino Acid Base Homemade

Introduced to solids at _____ months Introduced cow's milk at _____ months

Food/Juice allergies/intolerances? Yes No Describe: _____

Date of last physical exam: _____

Symptom description	**Yes**	**No**
Does the child experience pain every day?	o	o
Do symptoms interfere with daily life?	o	o
Does pain wake up the child at night?	o	o
Are the symptoms worse during certain times of the day?	o	o
Does the child wear orthotics	o	o
Does the child take vitamin supplements?	o	o
What activities aggravate symptoms?		

Have you ever:	**Yes**	**No**	**Briefly explain:**
Broken bones?	o	o	
Been hospitalized, not associated with pregnancy?	o	o	
Been hospitalized, associated with pregnancy?	o	o	
Been in an auto accident?	o	o	
Had sprains/strains?	o	o	
Been struck unconscious?	o	o	
Had surgery?	o	o	

Habits:	None	Light	Moderate	Heavy
Drugs, non-prescribed	o	o	o	o
Exercise	o	o	o	o
Sleep	o	o	o	o
Appetite	o	o	o	o
Water	o	o	o	o

Delivery History:

Place of Birth: Hospital Birthing center Home Midwife

Birth Practitioner: OB/GYN Certified Nurse Midwife Certified Practicing Midwife Lay Midwife

Was Labor Induced? Yes No – Natural start Unknown

If Yes, specify type: Pitocin Prostaglandin Gel (applied to your cervix) Unknown

How was the baby delivered? Vaginal VBAC Planned Caesarian Unexpected Caesarian

Were operative devices used to facilitate the birth? Yes No Unknown

If yes, which type? Forceps Vacuum Extraction

Insurance Information (if applicable)

Name of party responsible for payment: _____

Do you have health insurance? Yes No Name of company: _____

I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand and agree that all services rendered to me and charged are my personal responsible for timely payment. I understand that if I suspend or terminate my care/treatment, any fees for professional services to me will be immediately due and payable.

I hereby verify all information provided is correct and true. I understand the insurance agreement, as it pertains to my child's treatment.

I, _____, hereby authorize Dr. Jack Mawer and/or Dr. Sondra Konigsfeld to administer chiropractic care to my child, _____.

Parent/Guardian Signature _____ Date _____