

## 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?	<input type="radio"/>	<input type="radio"/>
Do symptoms interfere with daily life?	<input type="radio"/>	<input type="radio"/>
Does pain wake up the child at night?	<input type="radio"/>	<input type="radio"/>
Are the symptoms worse during certain times of the day?	<input type="radio"/>	<input type="radio"/>
Does the child wear orthotics	<input type="radio"/>	<input type="radio"/>
Does the child take vitamin supplements?	<input type="radio"/>	<input type="radio"/>
What activities aggravate symptoms?		

Have you ever:	Yes	No	Briefly explain:
Broken bones?	<input type="radio"/>	<input type="radio"/>	
Been hospitalized, not associated with pregnancy?	<input type="radio"/>	<input type="radio"/>	
Been hospitalized, associated with pregnancy?	<input type="radio"/>	<input type="radio"/>	
Been in an auto accident?	<input type="radio"/>	<input type="radio"/>	
Had sprains/strains?	<input type="radio"/>	<input type="radio"/>	
Been struck unconscious?	<input type="radio"/>	<input type="radio"/>	
Had surgery?	<input type="radio"/>	<input type="radio"/>	

<b>Habits:</b>	<b>None</b>	<b>Light</b>	<b>Moderate</b>	<b>Heavy</b>
Drugs, non-prescribed	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Exercise	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sleep	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Appetite	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Water	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**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** \_\_\_\_\_