

Dynamic Chiropractic & Wellness Center

INFANT/TODDLER HEALTH QUESTIONNAIRE

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TODAY'S DATE: _____

CHILD'S NAME: _____ PARENT'S NAMES _____

CHILD'S DATE OF BIRTH: _____

CHILD'S PEDIATRICIAN: _____

BIRTH WEIGHT: _____ BIRTH HEIGHT: _____

PRESENT WEIGHT: _____ PRESENT HEIGHT: _____

HISTORY

PLEASE DESCRIBE YOUR PRESENT COMPLAINT/REASON FOR VISIT:

WHEN DID COMPLAINT BEGIN? (Specify Date) _____

PLEASE DESCRIBE ANY PROBLEMS/DIFFICULTIES DURING PREGNANCY:

DID YOU TAKE PRE-NATAL VITAMINS DURING PREGNANCY? Yes No

DID YOU SMOKE DURING PREGNANCY? Yes No

DID YOU DRINK DURING PREGNANCY? Yes No

PLEASE CIRCLE TYPE OF DELIVERY (ALL THAT APPLY):

Natural Pelvic Block Epidural Induced C-section Hospital Home

PLEASE DESCRIBE LENGTH OF LABOR/DELIVERY: _____

WERE ANY OF THE FOLLOWING USED DURING DELIVERY: Suction Forceps

IS/WAS CHILD BREAST FED? Yes No HOW LONG? _____

WHAT TYPE OF FORMULA ARE YOU USING? _____

(Please turn over)

PLEASE DESCRIBE ANY CONCERNS WITH CHILD'S EATING HABITS OR SLEEPING HABITS:

PLEASE DESCRIBE FREQUENCY OF CHILD'S BOWEL HABITS: _____

IS CHILD CURRENTLY TAKING ANY MEDICATIONS? PLEASE LIST: _____

PLEASE DESCRIBE ANY OTHER HEALTH CONCERNS OF YOUR CHILD SINCE BIRTH. ANY SURGERIES? ANY TRAUMA? ETC.: _____

HAS YOUR CHILD SEEN ANY OTHER DOCTOR'S BESIDES PEDIATRICIAN? IF YES, WHO?

PLEASE CIRCLE ANY OF THE FOLLOWING CONDITIONS YOUR CHILD HAS SUFFERED FROM DURING THE PAST 6 MONTHS:

Ear infections	Asthma/Allergies	Colic	Digestion Problems	Bed Wetting
Seizures	ADHD	Car Accident	Other Trauma	Chronic Colds
Recurring Fevers	Headaches	Growing/Back Pains	Other _____	