Toddler and Child Case History (Ages 2 - 5 Years)

Please complete the following in as much detail as possible. Your answers will allow us to determine how best to care for your child.

Personal Information

Last Name: ______________________________ First Name: ______________________________

Parents'/Guardians' Names: ____

Address:______________________________City:__________________Postal Code: _______________

Home Phone:________________Other Phone:_______________Age:_______Birthdate: ____________

E-mail address:____

Medical Doctor:____________________________________Pediatrician: ________________________

Medical Services Plan (Care Card) Number: ____

What are your child's primary health challenges? ____

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What are your goals once these challenges have been addressed?______________________________

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Which other health professionals have you consulted regarding your child's health challenges?

____

Who may we thank for you referral to our office?____

Prenatal History

Complications during pregnancy: ____

Did you carry your child to full term? ☐ Yes ☐ No (If no, how early did you deliver?__________)

Did you use any medications or drugs during your pregnancy? ☐ Yes ☐ No

Labour and Delivery History

Was your labour:		☐ Spontaneous	☐ Induced
Was your labour unusually long?		☐ Yes	☐ No
Was your pushing phase unusually long?		☐ Yes	☐ No
Were any medications used during your labour?		☐ Yes	☐ No
Interventions used during your labour?	☐ Forceps	☐ Suction	☐ Heavy Manual Traction
If you had a C-section, was it:	☐ Emergency	or	☐ Non-Emergency

Health History

In the past six months, has your child experienced:

☐ Allergies________________________ ☐ Back or Neck Pain

☐ Bedwetting ☐ Bowel Difficulties

☐ Colds (more than normal) ☐ Ear infections

☐ Digestive Issues ☐ Food Sensitivities ________________

☐ Vaccine Reactions ☐ Sleep Difficulties

Developmental History

Were there any delays in your child achieving his/her developmental milestones? ☐ Yes ☐ No

If yes, please describe: ____________________

Have any learning or behavioral challenges been identified? ☐ Yes ☐ No

If yes, please describe: ____________________

Activity History

How long does your child spend working at the computer each day?

☐ 1 Hour or less ☐ 1-2 Hours ☐ 2 Hours or more

How much time does your child spend watching TV each day?

☐ 1 Hour or less ☐ 1-2 Hours ☐ 2 Hours or more

How much time does your child spend being active each day?

☐ 1 Hour or less ☐ 1-2 Hours ☐ 2 Hours or more

In which sports/activities is your child involved? ____________________

Trauma History

Has your child ever:

- ☐ Fallen from a height
- ☐ Been in a motor vehicle accident
- ☐ Fallen from a moving object
- ☐ Been the victim of physical/sexual abuse
- ☐ Fallen down the stairs
- ☐ Broken any bones
- ☐ Experienced any other trauma ____________________

Is there anything else you would like us to know about your child? ____________________

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Health Information:

What are your objectives in seeking chiropractic care? (please check all that apply)

- ☐ Relief of symptoms
- ☐ Improve sleep regulation
- ☐ Decrease the risk of symptoms returning
- ☐ Improve overall health and well being
- ☐ Improve emotional regulation
- ☐ Other (please list) ____________________
- ☐ Improve nerve function

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