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: _____

Medical Doctor: _____ Pediatrician: _____

Medical Services Plan (Care Card) Number: _____

What are your child's primary health challenges? _____

_____

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

_____

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

_____

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

E-mail address: _____

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 delivery: ☐ 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 _____
- ☐ Headaches
- ☐ Sleep Difficulties
- ☐ Vaccine Reactions

Developmental History

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

If yes, please describe: _____

Have any learning or behavioural 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/off of 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?_____

_____

_____