WELLNESS CHIROPRACTIC

20 East Blue Hill Road
PO Box 326
Blue Hill, ME 04614
Tel: 207-374-2186
Fax: 207-374-5235
www.mywellnesschiro.com

TODDLER HEALTH SURVEY (THREE TO FIVE YEARS)

Name: _____ Guardian:_____

Address: _____

City: _____ State:_____ Zip:_____

Home Phone: ____-____-_____ Work Phone: ____-____-_____ Cell Phone:____-_____-_____

Email Address*:_____

Date of Birth: _____ Social Security#:_____-_____-_____ Gender: ☐ Male ☐ Female

**We use your email address to subscribe you to our newsletter. Emailed monthly, each edition includes tips, tools, and wellness resources. Please check this box ☐ if you DO NOT want to receive this. You can visit our website to subscribe at anytime.*

Please indicate if your child has or ever had any of the following:

Back or neck pain	Y N	Pain in legs or arms	Y N
Torticollis (severe head tilt)	Y N	Headaches	Y N
Ear infections	Y N	Tubes in the ears	Y N
Has frequent colds, cough or runny nose	Y N	Had colic as an infant	Y N
Asthma	Y N	Allergies*	Y N
Eating difficulties	Y N	Constipation	Y N
Diarrhea, upset stomach	Y N	Bed wetting	Y N
Skin problems (eczema, rashes, etc.)	Y N	Childhood diseases	Y N

**If child does have allergies, please list below:*

_____

_____

_____

Trauma

Fall from a bicycle, scooter, skate board, etc.	Y N	Fall down the stairs	Y N
Fall from a significant height	Y N	Motor vehicle accident	Y N
Injuries (bone fracture, burn, cut, etc.)	Y N	Planned C-section	Y N
Trips and falls easily	Y N		

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Emotional Status:

Please check if your child has or ever had any of the following:

Sleeping difficulties	Y N	Cries a lot	Y N
Has frequent temper tantrums	Y N	Shy	Y N
Separation Anxiety	Y N	Afraid of new environment	Y N

Family History:

Does any one in the child's family have:

Asthma	Y N	Respiratory allergies	Y N
Food allergies	Y N	Takes vitamin supplements	Y N

Nutrition:

Please check if your child has received any of the following:

Breast Milk: _____ How long? _____
Formula (*please indicate the brand)*: _____
Cow's Milk (*please indicate the brand)*: _____
Soy Milk (*please indicate the brand)*: _____
Fruit Juices *(please indicate the brand)*: _____
Vegetable Juices *(please indicate the brand)*: _____
At what age was solid food introduced? _____ What was introduced first? _____

The child is a good eater	Y N	Likes a variety of foods	Y N
Has food allergies*	Y N	Takes vitamin supplements	Y N

**If child does have food allergies, please list below:*

_____

_____

_____

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Immunization Status:

☐ **Choosing not to immunize** ☐ **All up to date and current**

List the immunizations your child has received and any reaction you have observed:

Date	Immunization	Reaction
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Previous Health Care:

Name of Pediatrician: _____Name of Chiropractor: _____

Date of Last Exam: _____

Is your child under medical care for a specific condition? If so, please list the condition and the care received:

_____

_____

Do you have any concerns about your child's health? _____

_____