Dr. Taylor Trotter, D.C.

Patient History (Infant & Toddler- Birth to 3 years)

Personal Information

Last Name:_____First Name:_____

Parents'/Guardians' Names:_____
Address:_____City: _____

Postal Code:_____ Age:_____ Birthdate:_____

Home Phone:_____Other Phone:_____

E-mail address:_____

Medical Doctor:_____

Care Card Number:_____

What are your primary complaint/concern for your child?

_____

Have you consulted any other professionals regarding your child's health?

_____

Prenatal History

Complications during pregnancy:_____
Did you carry your child to full term? Yes_____ No_____

Did you use any medications or drugs during your pregnancy? Yes___ No___

Labour and Delivery History

Was your labour: Spontaneous_____ Induced_____

Medications used during labour_____

Were any of the following interventions used during delivery:

Forceps_____Suction_____ Heavy Manual Traction_____

Was the birth a C-section? If so, was it Emergency_____ or Non-Emergency_____

Health History

In the past six months, has your child experienced:

Allergies_____ Back_____Neck Pain_____Digestive issues_____

Headaches_____Bedwetting_____Cold/Flu_____

Sleep issues_____Ear infections_____Food Sensitivities_____

Bowel issues_____

Developmental History

Are there any concerns in regards to learning or behavior?

_____

Has your child experienced any of the following:

Motor vehicle accident _____Broken bones_____

Any other trauma_____

Please keep in mind that your treatment time is reserved specifically for you. A minimum of 24 hours notice for rescheduling or canceling appointments is required. There will be a charge of $25.00 for missed appointments or cancelations without 24 hours notice.

Please initial here to indicate you have read and understood this policy. _____

Parent's/Guardians' Signature:_____Date:_____