

Dr. Taylor Trotter, D.C.

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

Personal Information

Last Name: _____ First Name: _____

Preferred Pronouns: _____

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: _____