BACK TO HEALTH
CHIROPRACTIC

CONFIDENTIAL PEDIATRIC PATIENT HEALTH HISTORY

Today's Date: _____ Patient#:_____

PATIENT DEMOGRAPHICS

Name: _____ Birth Date: _____-_____-_____ Age: ____ ☐ Male ☐ Female

Address: _____ City: _____State: _____ Zip: _____

Guardian E-mail Address: _____ Guardian Phone #: _____

Weight: _____ Height: _____ Name(s) of Parents/Guardians:_____

Referred By:_____

Reason for Pursuing Care:_____

Other doctors seen for this condition: ☐ Yes ☐ No If yes, Doctors' names and prior treatments: _____

_____

Check any of the following conditions your child has suffered from during the past 6 months:

☐ Ear Infections	☐ Scoliosis	☐ Digestive Problems	☐ Chronic Colds	☐ Headaches
☐ Asthma/ Allergies	☐ Seizures	☐ Recurring Fevers	☐ ADHD/ ADD	☐ Colic
☐Growing Pains	☐ Bed Wetting	☐ Car Accident	☐ Temper Tantrums	☐ Scoliosis
☐ Reflux	☐ Neck/Upper Back Pain		☐Mid/Low Back pain	☐ Other: _____

DOCTORS NOTES:_____

_____

_____

_____

Family History: _____

Previous Chiropractic care: ☐ Yes ☐ No If yes, Chiropractor's Name:_____

Date of Last Visit: _____/_____/_____ Reason: _____

Name of Pediatrician: _____

Date of Last Visit: _____/_____/_____ Reason: _____

Are you satisfied with the care your child has received there? ☐ Yes ☐ No

Number of doses of antibiotics your child has taken:

In past 6 months: _____ Total during lifetime:_____

Vaccination history: _____

Present prescription drugs/dosage? _____

Past prescription drugs/dosage? _____

Over the counter drugs (Tylenol, cough syrup, laxatives, etc.)_____

FEEDING HISTORY

Breast Fed: ☐ Yes ☐ No How long?_____ Formula Fed: ☐ Yes ☐ No How long? _____ Type?_____

Introduced to: Solid Foods @_____ months Cow's milk @_____months

Food / Juice allergies or intolerance: ☐ Yes ☐ No List: _____

_____

PRENATAL HISTORY

Name of Obstetrician/ Midwife: _____

Complications during pregnancy? □ Yes □ No Explain: _____

Ultrasounds during pregnancy? □ Yes □ No How many: _____

Medications taken during pregnancy/ delivery? □ Yes □ No List: _____

Cigarette/ Alcohol use during pregnancy? □ Yes □ No

Location of Birth: □ Hospital □ Birthing Center □ Home

Birth Interventions: □ Induced □ Forceps □ Vacuum □ Caesarian Section

If Caesarian Section was it: □ Planned □ Emergency

Genetic disorders/disabilities? □ Yes □ No If Yes, List: _____

Birth Weight: _____ Birth Length: _____ APGAR Scores: _____-_____

DEVELOPMENTAL HISTORY

At what age was your child able to:

Respond to sound:_____ Cross Crawl: _____ Respond to visual stimuli: _____

Stand alone: _____ Hold head up: _____ Walk alone: _____

Sit Up:_____

According to the National Safety Council, approximately 50% of children fall head first from a high place during their first year of life (i.e. a bed, changing table, down stairs, etc). Was this this the case with your child?

□ Yes □ No

Is/ has your child been involved in any high impact or contact type sports (i.e. soccer, football, gymnastics, baseball, cheerleading, , martial arts, etc)? □ Yes □ No List: _____

Has your child ever been involved in a car accident? □ Yes □ No List:_____

Has your child ever been seen on an emergency basis? □ Yes □ No List: _____

Other traumas not described above? □ Yes □ No List: _____

Prior surgery? □ Yes □ No List: _____

Menses? □ Yes □ No Started at Age:_____

Chicken Pox: □ Yes □ No, Age:_____ Mumps: □ Yes □ No, Age: _____ Rubella: □ Yes □ No, Age:_____

Rubeola: □ Yes □ No, Age: _____ Whooping Cough: □ Yes □ No, Age: _____Other: _____ Age: _____

LIFESTYLE

Does your child: □ Eat organic food □ Drink clean, filtered water □ Take probiotics Type: _____

□ Take vitamins, Type: _____Exercise: □ none □ mild □ moderate □ heavy □ daily Type:_____

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

CONSENT TO TREAT A MINOR

By my signature below, I being the parent or legal guardian, herby authorize the doctor (s) of chiropractic who now or in the future treat me while employed by, working or associated with or serving as back-up for Back to Health Chiropractic Center.

_____	_____	_____
Name	Guardian Signature Date	Relationship to Patient

_____	_____
Doctor's Signature	Date Form Reviewed