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 ☐ Other: ____

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