Back 2 Health Chiropractic, LLC
845 E. Fairview Ave STE 115, Meridian ID 83642
Office: 208-893-5401 Fax: 208-893-5403
back2healthidaho.com

Pediatric History Form (For Children 12 Years and Under)

It is a pleasure to welcome you to our family of happy and healthy chiropractic patients here at Back 2 Health Chiropractic. Please let us know if there is any way we can make you and your family feel more comfortable. To help us serve you better, please complete the following information. We look forward to working with you to create better health for your family.

(Please Print) Patient Name:_____
Name You Prefer Us To Use: _____
Address:_____
City:_____ State:_____ Zip:_____
Home Phone: (_____)_____ Cell: (_____)_____
Date of Birth: _____ S.S.#_____-_____-_____ Gender: □ Female □ Male Weight:_____
Height:_____ Parent(s)/Guardian Name(s): _____
Referred By:_____
Reason for seeking care: _____
Have Other Doctors Been Seen for this Condition? □ Yes □ No If Yes, List Doctor Name(s) and Prior Treatments:_____
Any Other Health Problems?_____
Check Any of the Following Conditions Your Child Has Experienced During the Past Six Months:
____Ear Infections ____Digestive Problems ____Car Accident ____Headaches ____Asthma / Allergies ____Bed Wetting ____ Chronic Colds ____Growing / Back Pains ____Colic ____Seizures ____Recurring Fevers ____Autism ____Scoliosis ____ADD/ADHD ____Temper Tantrums Other:_____
Family History (any diseases):_____
Previous Chiropractor (If Any):_____ Date of Last Visit:_____
Reason:_____
Are You Satisfied with the Care Your Child has Received There: □ Yes □ No
Name of Pediatrician:_____ Date of Last Visit:_____
Reason:_____
Are You Satisfied with the Care Your Child has Received There: □ Yes □ No
Number of Antibiotics Your Child has Taken During the Past Six Months: _____ During His/Her Lifetime: _____ Number of Doses of Other Prescription Medications Your Child has Taken During the Past Six Months: _____ During His/Her Lifetime: _____
Please List Medications:_____
Vaccination History:_____
Prenatal History:
Name of Obstetrician/Midwife:_____
Complications During Pregnancy: □ Yes □ No
List Complications (if any):_____
Ultrasounds During Pregnancy: □ Yes □ No Number:_____ Medications During Pregnancy/Delivery: □ Yes □ No
List:_____
Cigarette/Alcohol Use During Pregnancy: □ Yes □ No
Location of Birth: □ Hospital □ Birthing Center □ Home Birth
Intervention: □ Forceps □ Vacuum Extraction □ Caesarian Section ___Yes___No If C-Section: □ Emergency □ Planned
Complications During Delivery: □ Yes □ No
List:_____

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Genetic Disorders or Disabilities: □ Yes □ No
List:_____
Birth Weight:_____ Birth Length:_____ APGAR Scores:_____ _____ Feeding History:
Breast Fed: □ Yes □ No How Long? _____ Formula Fed: □ Yes □ No How Long?_____ Introduced to Solids at _____ Months Introduced to Cows' Milk at _____ Months Food/Juice Allergies or Sensitivities: □ Yes □ No
List:_____
_____

Developmental History: During the following developmental stages your child's spine is most vulnerable to stresses and should routinely be checked by a doctor of chiropractic for prevention and early detection of vertebral subluxation (spinal nerve interference).

At what age was your child able to: Respond to Sound:_____ Respond to Visual Stimuli:_____ Hold Head Up:_____ Sit Up:_____ Cross Crawl:_____ Stand Alone:_____ Walk Alone:_____

According to the National Safety Council, approximately 50% of children fall head-first from a high place during their first year of life (for example: a bed, changing table, stairs, etc.).

Has your child had a head-first fall? □ Yes □ No If yes at what age:_____

Is/has your child been involved in any high impact or contact 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 Been Seen on an Emergency Basis? □ Yes □ No
List:_____

Other Traumas Not Described Above? □ Yes □ No
List:_____

Prior Surgery: □ Yes □ No
List:_____

Childhood Diseases: Please mark all that apply.
Chicken Pox: Age:_____ Mumps: Age:_____ Rubella: Age:_____
Whooping Cough: Age:_____ Rubeola: Age:_____ Other(s)
List:_____

We are here to serve you and we encourage you to ask questions. Your participation is vital and will help determine your child's results.

Authorization for Care of Minor: I hereby authorize Back 2 Health Chiropractic LLC, its Doctors and Staff to administer Chiropractic care to my Son/Daughter as they deem necessary. I clearly understand and agree that I am personally responsible for payment of all fees at the time services are rendered.

Name of Parent/Guardian:_____Date: _____
Signature of Parent/Guardian:_____