

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

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: _____

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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: _____