BACK TO HEALTH CHIROPRACTIC

Pediatric Patient History Form (Up to 8 Years of Age)

Today's Date: _____/_____/_____

Patient's Name: _____ Date of Birth: _____/_____/ _____

Mother's Name: _____ Father's Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Primary Phone #: (_____) _____-_____ Secondary Phone#: (_____) _____-_____

Age: _____ Sex: _____ Number of Siblings: _____ Referred by: _____

Pediatrician/Family MD: _____ Date of Last Visit: _____/_____/_____

Purpose of Last Visit: _____

Birth Weight: _____ Birth Length: _____ Currently Weight: _____ Currently Length: _____

Ever Been Under Chiropractic Care: □ No □ Yes Who/When? _____

Who is responsible for this bill? □ Mother □ Father □ Other (please explain) _____

Insurance Company: _____

Purpose for this Chiropractic Visit: _____

Pregnancy History:

Third Trimester Presentation: □ Vertex □ Breech □ Transverse □ Face/Brow

Type of Birth (Please Check):

□ Normal Vaginal □ Forceps □ Cesarean □ Suction Cap or Vacuum

Location: □ Home □ Birthing Center □ Hospital

Problems during Pregnancy: _____

Problems during Labor/Delivery: _____

Apgar Scores:____ ____ Was There Presences at Birth of: Jaundice (Yellow)?_____ Cyanosis (Blue)?____

Congenital Anomalies/Defects? _____ If Yes, Please Explain? _____

Infant History:

Infant Feeding: □ Breast □ Bottle □ Formula If Formula, What Brand? _____

Number of Hours Sleeping per Night: _____ Quality of Sleep: □ Good □ Fair □ Poor

Immunization? □ None □ Up to Date with All Recommended □ Not Up to Date

List all IMMUNIZATIOINS your child has had:_____

Has your child ever been treated at the emergency room? _____ If yes; please explain_____

_____

Has your child ever been hospitalized? _____If yes; please explain _____

Has your child ever had any surgeries? _____ If yes; please explain _____

Is your child currently on any medication? _____ If yes; please list _____

At What Age Did The Child:

Respond to Sound: _____ Follow an Object with His/Her Eyes: _____ Hold Head Up: _____

Sit Alone: _____ Crawl: _____ Stand: _____ Walk Alone: _____

At What Age, If Ever, Did The Child Suffer From The Following:

Chicken Pox: _____ Mumps: _____ Measles: _____ Rubella: _____ Whooping Cough: _____

Other: _____

Has Your Child Ever Suffered From:

- □ Headaches
- □ Orthopedic Problems
- □ Digestive Disorders
- □ Behavioral Problems
- □ Dizziness
- □ Neck Problems
- □ Poor Appetite
- □ ADD/ADHD
- □ Fainting
- □ Arm Problems
- □ Stomach Aches
- □ Growing Pains
- □ Chronic Earaches
- □ Backaches
- □ Diarrhea
- □ Sinus Trouble
- □ Leg Problems
- □ Reflux
- □ Ruptures/ Hernia
- □ Muscle Pain
- □ Seizures/ Convulsions
- □ Heart Trouble
- □ Joint Problems
- □ Constipation
- □ Poor Postures
- □ Hypertension
- □ Asthma
- □ Scoliosis
- □ Anemia
- □ Colds/Flu
- □ Walking Trouble
- □ Bed Wetting
- □ Colic
- □ Broken Bones
- □ Sleeping Problems
- □ Allergies to: _____
- □ Other: _____

Has Your Child Ever Sustained an Injury from an Auto Accident? □ No □ Yes

If yes; please explain: _____

Authorization for Care of Minor/ Financial Agreement

I understand that I am directly and fully responsible to Back to Health Chiropractic Clinic for all chiropractic care my child receives. I hereby authorize this clinic and its doctor(s) to administer care as they so deem necessary for my child. I realized that I am responsible for all fees charged by this clinic and that I will pay for all services as they are performed. I understand and agree that x-rays remain the property of this clinic.

We require both biological parents to consent and agree for your child to receive care at BTH Clinic.
Do both biological parents consent for your child to receive care at this office? □ Yes □ No

Mother's Signature: _____ Date Signed: _____/_____/_____

Father's Signature: _____ Date Signed: _____/_____/_____

Chiropractic Assistant's Signature: _____ Date Signed: _____/_____/_____

Sole Provider: By Signing Below, I am Stating that I am the Legal **Sole** Provider of this Child:

Sole Custodian's Signature: _____ Date Signed: _____/_____/_____