



WELCOME TO BACK & BODY CHIROPRACTIC
PEDIATRIC FORM

Name:		Today's Date:	
What Patient Prefers to be Called:			
Parents'/Guardian's Names:			
Home Phone:		Parent's Cell:	
Mailing Address:		City:	Zip:
Child's Birth Date:	Age:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security #:
Parent's Email Address (for newsletter and appointment information):			
How did you learn about our office?			
Previous Chiropractic Care? <input type="checkbox"/> Yes <input type="checkbox"/> No		Approximate Last Visit Date:	

Please check reasons for pursuing chiropractic care for your child:

- ___ He/She is continuing ongoing care from another chiropractor.
- ___ I recently had my spine checked and see the value in getting my child checked.
- ___ I'm concerned about his/her health and I'm looking for answers.
- ___ He/She has a specific condition that concerns me.

Explain condition or symptom:

- ___ I want to improve my child's immune function.
- ___ I have no idea why we're here. Please take the time to explain to me what you do for children.

In order for us to better understand your child's current level of health, please check any of the following body signals which he/she has or has had previously:

- Headaches/Migraines Asthma Sleep Problems Weight Problems ADD/ADHD
- Postural Imbalance PDD/Autism Seizures Frequent Colds Allergy/Sinus Problems
- Bedwetting Ear Infection Car Accident Colic Digestive Problems
- Scoliosis Growing/Back Problems

Other:

Number of doses of antibiotics your child has taken:

During the past 6 months: _____

Total during his/her lifetime: _____

List reasons: _____

Number of doses of other prescription medications your child has taken:

During the past 6 months: _____

Total during his/her lifetime: _____

List reasons: _____

Prenatal History:

Adopted Yes No

Complications during pregnancy? Yes No

List reasons: _____

Ultrasounds during pregnancy? Yes No Number: _____

Medications/drugs/caffeine use during pregnancy? Yes No

List: _____

Cigarette/Alcohol use during pregnancy? Yes No

Location of birth: Hospital Birthing Center Home

Birth Intervention:

Mother Induced Mother medicated (Pitocin, etc.) Caesarian Section

Forceps Vacuum Extracted Baby given medication after delivery

Complications during delivery? Yes No List: _____

Genetic Disorders or Disabilities? Yes No List: _____

Breast Fed? Yes No How Long? _____ Formula Fed? Yes No How Long? _____

Food or Other Allergies? Yes No List: _____

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

Yes No List: _____

Is/Has your child been involved in any high-impact or contact-type sports (ex. Soccer, football, gymnastics, hockey, basketball, cheerleading, martial arts, etc.)?

Yes No List: _____

Has your child been seen in an emergency room?

Yes No List: _____

Prior surgery? Yes No List: _____