BACK 2 BACK CHIROPRACTIC
A Family Wellness Place

Dr. Steven Wallin, D.C.

Pediatric Health History Record (Age 0 – 9 years old)

Child's Name _____ Gender _____ SS# _____
Address _____ City _____ State _____ Zip _____
Home Phone Number _____ Date of Birth _____ Age _____
Weight _____ Height _____ Referred by _____
Siblings (Names & Ages) _____
Race/Ethnicity (Please circle): Caucasian African American Hispanic American Indian/Alaska Native
Asian/Pacific Islander Other _____
Primary language spoken _____ Secondary language spoken _____

Mother's Name _____ SS# _____
Address (if different) _____ City _____ State _____ Zip _____
Cell Phone Number _____ Email address _____
May we contact you by phone call, text and/or email? Please circle: Yes / No

Father's Name _____ SS# _____
Address (if different) _____ City _____ State _____ Zip _____
Cell Phone Number _____ Email address _____
May we contact you by phone call, text and/or email? Please circle: Yes / No

1. FAMILY MEDICAL HISTORY

Please check if any blood relatives to the patient had any of the following illnesses & mark accordingly by noting: **M** (Mother); **F** (Father); **S** (Sibling); **PGM** (Paternal grandmother); **MGM** (Maternal grandmother); **PGF** or **MGF**.

_____ Allergy
_____ Asthma
_____ Birth Defect _____
_____ Cancer _____
_____ Diabetes / Low Blood Sugar
_____ Eczema / Psoriasis
_____ Heart Trouble
_____ Other (Please explain) _____

_____ High Blood Pressure / Stroke
_____ Kidney Disease
_____ Liver Disease
_____ Mental Illness / Nervous Disorders
_____ Scoliosis
_____ Seizures / Epilepsy
_____ Ulcer

2. PREGNANCY HISTORY

Please check any area that applied to the patient's mother during her pregnancy.

_____ Abnormal Bleeding
_____ Allergic Reactions
_____ Anemia
_____ Asthma
_____ Attitude – Happy or Depressed
_____ Back Pain or Other Pain
_____ Caffeine
_____ Chiropractic Care
_____ Complications
_____ Diabetes
_____ Excessive Increase / Decrease in Weight
_____ Heart Problems
_____ High / Low Blood Pressure
_____ Hospitalizations

_____ Indigestion
_____ Medications
_____ Mental Illness
_____ Morning Sickness
_____ Physical Injury (Fall, Car Accident)
_____ Premature Contractions
_____ Prenatal Classes
_____ Recreational Drugs / Cigarettes / Alcohol
_____ Seizures
_____ Swelling
_____ Thyroid Problems
_____ Ultrasounds
_____ Vitamins / Minerals
_____ Other (Please Explain) _____

3. LABOR & DELIVERY HISTORY

_____ Birthing Center
_____ Breastfeed at Birth
_____ Breech
_____ Cesarean
_____ Complications
_____ Doula
_____ Other (Please Explain) _____

_____ Epidural
_____ Fetal Monitor Used
_____ Forceps Used
_____ Greater than 12 hours
_____ Home Birth
_____ Hospital Birth

_____ Induced Birth
_____ Meconium Staining
_____ Medication_____
_____ Midwife
_____ Premature Delivery
_____ Vacuum Extraction

4. NATAL HISTORY

The duration of the pregnancy was _____weeks.
The APGAR score at birth was _____.
The APGAR score at 5 Minutes was _____.
The length at birth was _____.
The weight at birth was _____.

Please check any **problems** the patient had **at birth**:

_____ Breastfeeding Problems
_____ Bottle Feeding Problems
_____ Breathing / Cyanotic (Blue)
_____ Choking
_____ Other (Please explain) _____

_____ Colic
_____ Crying
_____ Jaundice (Yellow)
_____ Sleeping Problems

Please check if any item(s) applied to the patient **at birth**:

_____ Artificial Feeding
_____ Birthmarks _____
_____ Circumcision
_____ Medication _____

_____ Vitamin K (For Clotting)
_____ Silver Nitrate
_____ Surgery _____
_____ Other (Please explain) _____

5. NUTRITION HISTORY

Please check if the patient has received any of the following items **since birth**:

_____ Breast Milk (How long? _____)
_____ Commercial Formula
_____ Cow's Milk
_____ Goat's Milk
_____ Soy Milk
_____ Other (Please explain) _____

_____ Juice: Fruit / Vegetable
_____ Medications _____
_____ Solid Foods
_____ Sweets
_____ Vitamins _____

6. DEVELOPMENTAL HISTORY

Please indicate the age in which the patient performed the following item(s):

_____ Respond to Sound Stimuli
_____ Respond to Visual Stimuli
_____ Hold Head Up
_____ Sit Upright
_____ Roll Over

_____ Crawl
_____ Stand
_____ Cruise Furniture
_____ Walk
_____ Run

7. REASON FOR THIS VISIT

Describe the purpose of this visit: _____
When did this condition begin? _____

Please indicate if this condition has/is:

_____ Worsened	_____ Constant	_____ Better in AM
_____ Improved	_____ Intermittent (Comes and Goes)	_____ Better in PM

Please indicate if this condition interferes with:

_____ Bowel Movements	_____ Eating / Drinking	_____ School
_____ Daily Routine	_____ Recreational / Play activities	_____ Sleeping
_____ Other activities _____		

Has this condition occurred before? _____ Yes _____ No
Has the child seen other doctors for this condition? _____ Yes _____ No
If yes, Doctor's Name & Location: _____
Type of treatment: _____
Results: _____

8. CHILD'S HEALTH HISTORY

Please indicate each of the diseases or conditions that the child has now or has had in the past.

_____ Allergies	_____ Eczema / Psoriasis	_____ Scoliosis
_____ Asthma	_____ Fractures	_____ Seizures / Epilepsy
_____ Attention Problems	_____ Growing Pains	_____ Skin Problems
_____ Autism	_____ Hay Fever	_____ Sleeping Problems
_____ Back Pain	_____ Headaches	_____ Speech Problems
_____ Bed Wetting	_____ Hives	_____ Sports Injury
_____ Bowel Movements	_____ Hyperactivity (ADHD)	_____ Stomach Pain
_____ Breathing Problems	_____ Intestinal Gas	_____ Teeth Problems
_____ Chronic / Frequent Colds	_____ Irritability	_____ Temper Tantrums
_____ Colic	_____ Irritable Bowel Syndrome	_____ Tubes In Ears
_____ Constipation	_____ Knee Pain	_____ Urinating (Pain, Smell)
_____ Diarrhea	_____ Nail Problems	_____ Vision Problems
_____ Digestive Problems	_____ Neck Pain	_____ Vomiting
_____ Ear Problems	_____ Recurring Fevers	_____ Walking Problems
_____ Other (Please explain) _____		

According to the National Safety Council, approximately 50% of children fall head first from a high place during their first years of life, (i.e. off a bed, couch, changing table, down stairs, etc)
Was this the case with your child? _____ Yes _____ No

Please indicate if your child has ever had or experienced any of the following & describe details if applicable:

_____ Been Hospitalized? _____

_____ Been in a Car Accident? _____

_____ Had a Serious Fall? (Bicycle, Skateboard, Rollerblades, etc) _____

_____ Had any Broken bones? _____

_____ Had any Surgeries? _____

_____ Has or had any major illnesses? _____

9. VACCINATIONS & MEDICATIONS

Have you chosen to vaccinate your child? _____ Yes _____ No

Please indicate which of the following vaccines your child has received:

_____ DTaP (Diptheria, Tetanus, Pertusis)
_____ Gardisil (For Females)
_____ Hepatitis B
_____ Hib (Haemophilus Influenza type B)
_____ MMR (Measles, Mumps, Rubella)
_____ Pneumococcal conjugate (PCV)
_____ Polio
_____ Varicella (Chicken Pox)
_____ Other (Please explain) _____

Please describe any and all reactions to the vaccines: _____

_____

Please indicate if you have you had any foreign travel (where & when): _____

Please indicate any medications and the dates that your child has or is taking:

_____ Antibiotics _____ Aspirin _____ Ibuprofen
_____ Anti-Gas Medicine _____ Cold Medicine _____ Tylenol
_____ Other Over-The-Counter Medicine _____
_____ Other Prescribed Medicine _____

Has your child had any reactions to any medications? _____ Yes _____ No
If yes, please explain: _____

Name & Location of Pediatrician: _____
Date of last visit: _____ Reason: _____

10. AUTHORIZATIONS & CONSENT TO TREAT

I agree to assume responsibility for any charges created/incurred by the chiropractic care, and give consent for my child to be examined and/or treated by Dr. Wallin and/or his staff. I hereby authorize assignment of my insurance rights and benefits (if applicable to the provider for services rendered).

Parental Signature_____ **Date**_____