

Basin View Chiropractic PEDIATRIC HISTORY FORM

Dear New Patient,

It is a pleasure to welcome you to our family of happy and healthy chiropractic patients. 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 build better health for your family.

Patient's Name _____ D.O.B. (M/D/Y) ___/___/___ Age ____
 Address _____ Home Phone _____
 City _____ Other Phone _____
 Postal Code _____ Grade _____ Sex _____ Weight _____ Height _____

Name of Parents or Legal Guardian _____

Purpose For Contacting Us?: _____

Other Doctors Seen for this Condition: (please circle)

N Y Doctors' Names and Prior Treatments: _____

Other Health Problems?:

Check any of the Following Conditions Your Child has Suffered from During the Past Six Months:

- | | | | | |
|---|---|---------------------------------------|---|---|
| <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Seizures | <input type="checkbox"/> Chronic Colds | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Asthma / Allergies | <input type="checkbox"/> Digestive Problems | <input type="checkbox"/> ADHD | <input type="checkbox"/> Recurring Fevers | <input type="checkbox"/> Growing/Back Pains |
| <input type="checkbox"/> Colic | <input type="checkbox"/> Bed Wetting | <input type="checkbox"/> Car Accident | <input type="checkbox"/> Temper Tantrums | <input type="checkbox"/> Other _____ |

Family History: _____

Previous Chiropractor: _____ and _____

Date of Last Visit: ___/___/___

Food / Juice Allergies or Intolerances: _____ N , _____ Y , List: _____

Developmental History:

During the following times your child's spine is most vulnerable to stress and should routinely be checked by a doctor of chiropractic for the prevention and early detection of vertebral subluxation (spinal nerve interference). At what age was your child able to:

_____ Respond to Sound	_____ Cross Crawl
_____ Respond to Visual Stimuli	_____ Stand Alone
_____ Hold Head Up	_____ Walk Alone
_____ Sit Up	

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

Is / has your child been involved in any high impact or contact type sports (i.e., Soccer, Football, Gymnastics, Baseball, Cheerleading, Martial Arts, etc.) ? _____ N _____ Y , List: _____

Has your child ever been involved in a car accident?: _____ N, _____ Y, List: _____.

Has your child been seen on an emergency basis?: _____ N, _____ Y, List: _____.

Other Traumas not described above?: _____ N, _____ Y, List: _____.

Prior Surgery?: _____ N, _____ Y, List: _____.

Menarche?: _____ N, _____ Y, List: _____.

Childhood Diseases: (please circle)

Chicken Pox N / Y, Age _____ Mumps N / Y, Age _____

Rubella N / Y, Age _____ Whooping Cough N / Y, Age _____

Rubeola N / Y, Age _____ Other N / Y, Age _____

WE ARE HERE TO SERVE YOU, AND ENCOURAGE YOU TO ASK QUESTIONS.
YOUR PARTICIPATION IS VITAL AND WILL HELP DETERMINE YOUR RESULTS.