Back in Balance
A centre for wellbeing

Date:____________________

PEDIATRIC HISTORY

Surname:______________________________Given Name:______________________________Initial: ________

Address______________________________ City__________________ Province__________

Postal Code__________ Email ____________________

Gender ☐ Male ☐ Female Birth date(mm/dd/yy)____________ Age_______Home Phone #________________

Parent/Guardian______________________________ Parent/Guardian Work #:________________________

Parent/Guardian______________________________Parent/Guardian Work #: ________________________

Birth Weight________ Current Weight____________ Birth Length________ Current Length/Height____________

Siblings Names & Ages____

____

Referred to our Office by____

Purpose for contacting us____

Other Chiropractors seen for this concern____

Date of last visit________________ Reason for visit______________________________

Other Doctors seen for this concern____

Date of last visit________________ Reason for visit______________________________

Name of Pediatrician____

Date of last visit________________ Reason for visit______________________________

Other health concerns? ____

Check any of the following conditions that may apply to your child:

☐ Ear Infections	☐ Scoliosis	☐ Seizures	☐ Chronic Colds	☐ Headaches
☐ Asthma/Allergies	☐ Digestive Problems	☐ ADHD	☐ Recurring Fever	☐ Growing/Back Pains
☐ Colic	☐ Bed Wetting	☐ Car Accident	☐ Temper Tantrums	☐ Other__________

Number of Rounds of ***Antibiotics*** your child has taken:

In the last 6 months____________________ Total during life span____________________

Number of Rounds of ***Other Prescription Medications*** your child has taken:

In the last 6 months____________________ Total during life span____________________

Has your child received vaccinations? ☐ No ☐Yes If yes, please list vaccines, dates & any reactions________________

____

591 Byron Avenue
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Web Site: www.backinbalancechiro.ca

Prenatal History:

Name of Midwife/Obstetrician______________________________________ Number of weeks gestation____________

Location of birth: ☐ Home ☐ Birthing Center ☐ Hospital

Complications during pregnancy? ☐ No ☐ Yes If yes, please list ____

Ultrasound exams during pregnancy? ☐ No ☐ Yes If yes, how many______________________________________

Birth interventions? ☐ Induction ☐ Artificial rupture of membranes ☐ Forceps ☐ Vacuum extradition ☐ C-section, ER or planned

Complications during Labor/Delivery? ☐ No ☐ Yes If yes, how many______________________________________

Genetic Disorders/Anomalies? ☐ No ☐ Yes If yes, please list____

Medications during pregnancy? ☐ No ☐ Yes If yes, please list____

Cigarette/Alcohol use during pregnancy? ☐ No ☐ Yes If yes, please list______________________________________

Feeding History:

Breast fed? ☐ Yes ☐ No How long?_______________ Formula fed? ☐ Yes ☐ No How long?_______________

Introduced to solid food at what age?___________________________ Cow's milk at what age?______________________________

Food/juice allergies/intolerances ☐ No ☐ Yes If yes, please list____

Child's Habits	**Amount & Frequency**
_______Dairy	______________________________
_______NutraSweet (aspartame)	______________________________
_______Soda pop (reg./diet)	______________________________
_______Snoring	______________________________
_______Clenching/Grinding teeth	______________________________
_______Carry heavy bag/backpack	☐ Right side ☐ Left side

Sleep posture ☐ Right side ☐ Left side ☐ Back ☐ Stomach

Hours of sleep per day ____________

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Developmental History:

During the following milestones of development, your child's spine is most vulnerable to stress and should routinely be checked by a Doctor of Chiropractic for prevention and early detection of vertebral subluxation and spinal nerve interference.
At what age was your child able to:

_______Respond to sound _______Cross crawl _______Respond to visual stimuli (3+ mos.)

_______Stand alone _______Hold head up (5-6 mos.) _______Walk alone _______Sit up (9-10 mos.)

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. from a bed, changing table, down the stairs, etc.) Is this the case with your child? ☐ No ☐ Yes

Is/has your child been involved in any high impact or contact sports (i.e. soccer, football, gymnastics, basketball, baseball, cheerleading, martial arts, etc.)? ☐ No ☐ Yes If yes, please list____

Has your child ever been involved in a car accident? ☐ No ☐ Yes If yes, please list______________________________

Has your child ever been seen on an emergency basis? ☐ No ☐ Yes If yes, please list____________________________

Prior surgeries? ☐ No ☐ Yes If yes, please list____

Date of first menstrual cycle (if applicable)?__________________________________

Childhood Diseases:

Chicken Pox ☐ No ☐ Yes Age________

Rubeola (Measles) ☐ No ☐ Yes Age__________

Rubella (German Measles) ☐ No ☐ Yes Age___________

Mumps ☐ No ☐ Yes Age____________

Whooping Cough ☐ No ☐ Yes Age___________

Other_________________ ☐ No ☐ Yes Age___________

Health Attitudes:

_______***Treatment only*** I only consult a doctor when I or my child have/has an ache or pain and discontinue as soon as it has cleared up.

_______***Prevention*** In addition to symptomatic treatment, I consult specialists occasionally to prevent problems from recurring.

_______***Maintaining health*** I'm conscious about my health, diet, exercise, etc. and actively pursue these in order that I and my family feel better, perform better and it maximizes each of our potential.

_______***Family health*** I take an active part in assisting, informing and maintaining health with my family. I'm concerned with long term effects of good health and wellness.

Please initial to confirm that you have read the office fees and policies ______

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