Performance Chiropractic Clinic
Pediatric record

Child's Name:_____ Parent/Guardian(s):_____

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

Home Phone: (____)_____-_____ Cell Phone: (____)_____-_____ Work Phone: (_____)_____-_____

Child's Birthdate: ____/____/____ Age:_____ Sex:_____ School Attended: _____

Emergency Contact (if different than above):_____ Telephone Number:(_____)_____-_____

Has your child had previous chiropractic Care?_____ By Whom?_____ When?_____

Pediatrician:_____ Telephone Number:(_____)_____-_____

How did you hear of us?: yellow pages internet Dr. referred patient referral other:_____

What brings you in today?

List your health concerns/symptoms that brings you and your child in today:

_____

_____

_____

Additional Symptoms:
Circle all that apply

Headaches	Fatigue	Dizziness	Bedwetting
Neck Pain	Depression	Light sensitivity	Colic
Stiff Neck	Sleeping Problems	Bladder/Urinary	Diarrhea
Back Pain	Scoliosis	Infections	Acid Reflux
Nervousness	Ear Pain	Ringing in ears	Constipation
Tension	"Growing" Pains	Fever	Loss of balance
Irritability	Chest Pains	Loss of taste/smell	Allergies
			Fainting

Which of the above symptoms is worst? _____

How long has your child had it? _____

When is it at its worse? _____

Indicate how these symptoms cause your child to feel/act:

Moody/Irritable
Disruptive Sleep
Restricting to daily activities
Angry
Other:_____

Birth Information:
Vaginal delivery or C- section**:** _____
Anesthesia used**:** yes / no If yes,type:_____
Total hours of Labor**:**_____
Where did the birth take place: Home/ Hospital / Birthplace : _____
Any Birth Incidents, intervention, or trauma ie: Forceps/Vacuum Extraction**:** _____

Pregnancy Information:
Was the mother under regular chiropractic care? Y / N
Did the mother take vitamins during gestation? Y / N
What was the mother's health condition during pregnancy? Excellent / Good / Poor
Did the mother consume any over the counter, prescription, or other medications during Pregnancy? Y/ N
If yes, please list them: _____

Child's Health History:
According to the National Safety Council, approximately 50% of infants fall head first from a high place (bed,changing table, etc.) during their first year of life.
Has your child had any falls or injuries: Y / N
If yes, when and please explain**:**_____
Has your child ever taken prescriptions, including antibiotics? Y / N
If yes how many in the past 6 mos?____ Total during lifetime?_____
Has your child ever been breast fed? Y / N If yes, for how long? _____
Has your child ever been fed formula? Y / N If yes, what kind and for how long? _____

Previous Hospitalizations
_____

Diagnosed Diseases/Conditions/Syndromes:
_____

Medications your child currently takes: _____

Any other information you would like the chiropractor to know?
_____

We appreciate your time and concern regarding the matters that impact your child's health. A brief, non-invasive spinal health screening will be performed to determine if your child has any functional or structural spinal problems. Spinal misalignments at any early age can cause nervous system stress (vertebral subluxation) that can interfere with your child's optimum health and immune function. Chiropractic care helps your child's growing spine and improves their health!

Parent Signature_____ Date: ___/___/___

Doctor Signature_____ Date: ___/___/___