CHIROPRACTIC
Performance Center

2380 Troop Drive • Suite 201 • Sartell, MN 56377
Phone: 320-255-0961 • Fax: 320-258-4001
Email: info@ChiroPerformanceCenter.com
Web: www. ChiroPerformanceCenter.com

PEDIATRIC PATIENT INFORMATION

Child's Name: ______________ Mother's Name: ______________ DOB: ________
Case Number: ______________ Father's Name: ______________ DOB: ________
Address: ______________ City: ______________ State: ______ Zip: ________
Home Phone: ____________ Mother's Work Phone: ____________ Mother's Cell Phone: ____________
Email: ____________ Father's Work Phone: ____________ Father's Cell Phone: ____________

Cell Phone Carrier: ____________ May we contact you via text messaging? ❑ Yes ❑ No

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Birth Date: ____________ Age: ______ Sex: ❑ Male ❑ Female Number of Siblings: ______ Referred By: ____________
Birth Weight: ____________ Birth Length: ____________ Current Weight: ____________ Current Length: ____________

Third Trimester Presentation: ❑ Vertex ❑ Breech ❑ Transverse ❑ Face/Brow
Type of Birth: ❑ Normal Vaginal ❑ Forceps ❑ Cesarean ❑ Suction Cap or Vacuum Location: ❑ Home ❑ Birthing Center ❑ Hospital
Problems During Pregnancy: ______________________________
Problems During Labor/Delivery: ______________________________
Apgar Scores: ______ ______ Was there presence of birth of: ❑ Jaundice (Yellow)? ❑ Cyanosis (Blue)? ❑ Congenital Anomalies/Defects
if yes, please explain: ______________________________

Infant Feeding: ❑ Breast ❑ Bottle if bottle, which formula? ______________________________
Number of hours sleeping at per night: ________ Quality of sleep: ❑ Good ❑ Fair ❑ Poor

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Obstetrician/Midwife: ______________ Pediatrician/Family MD: ______________
Date of last visit: ____________ Purpose: ______________________________
Immunization History: ______________________________
Number of doses of antibiotics your child has taken: During the past 6 months ____________ During his/her lifetime ____________
Previous Chiropractor: ______________________________ Date of last visit: ____________
Purpose: ______________________________
Has your child ever been treated on an emergency basis? ❑ Yes ❑ No If yes, please explain ______________________________

Purpose of this appointment: ______________________________
Insurance/Billing information: ______________________________ Policy Number: ______________

AUTHORIZATION FOR CARE OF MINOR

I hereby authorize this office and it's Doctor(s) to administer care as they so deem necessary to my son/daughter/ward (upon approval of parent or guardian).

Signed: ______________________________ Date: ____________

I realize that I am responsible for all fees charged by this office and I agree to pay for all services provided. X-Rays remain the property of this office.

Signed: ______________________________ Date: ____________

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PEDIATRIC CASE HISTORY

Delivery/Birth History: ____

____

____

At what age did the child : Respond to sound ____________ Follow and object with his/her eyes ____________ Hold up head ____________

Sit alone ____________ Crawl ____________ Stand ____________ Walk alone ____________

At what age, if ever, did this child suffer from the following childhood diseases? Chickenpox ____________ Mumps ____________

Measles ____________ Rubella ____________ Rubeola ____________ Whooping Cough ____________ Other ________________

Has this child ever suffered from:

- ❑ Headaches
- ❑ Dizziness
- ❑ Fainting
- ❑ Seizures/Convulsions
- ❑ Heart Trouble
- ❑ Chronic Earaches
- ❑ Sinus Trouble
- ❑ Asthma
- ❑ Colds/Flu
- ❑ Colic
- ❑ Orthopedic Problems
- ❑ Neck Problems
- ❑ Arm Problems
- ❑ Leg Problems
- ❑ Joint Problems
- ❑ Backaches
- ❑ Poor Posture
- ❑ Scoliosis
- ❑ Walking Trouble
- ❑ Broken Bones
- ❑ Digestive Disorders
- ❑ Poor Appetite
- ❑ Stomach Aches
- ❑ Reflux
- ❑ Constipation
- ❑ Diarrhea
- ❑ Diabetes
- ❑ Hypertension
- ❑ Anemia
- ❑ Bed Wetting
- ❑ Behavioral Problems
- ❑ ADD/ADHD
- ❑ Ruptures/Hernia
- ❑ Muscle Pain
- ❑ Growing Pains
- ❑ Allergies to ________________
- ❑ Allergies to ________________
- ❑ Allergies to ________________
- ❑ Other ________________
- ❑ Other ________________

Has this child ever suffered the following spinal traumas?

- ❑ Fall in baby walker
- ❑ Fall from crib
- ❑ Fall from highchair
- ❑ Fall from changing table
- ❑ Fall from bed or couch
- ❑ Fall off swing
- ❑ Fall off slide
- ❑ Fall off monkey bars
- ❑ Fall off skateboard or skates
- ❑ Fall off bicycle
- ❑ Fall down stairs
- ❑ Other ______________________________

Has this child ever sustained and injury playing organized sports? ❑ Yes ❑ No If yes, please explain ______________________________

____

Has this child ever sustained injuries in an auto accident? ❑ Yes ❑ No If yes, please explain ______________________________

____

Present History: ____

____

____

Surgery: ______________________________ Medications: ______________________________

Accidents: ____

Family History: ____

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FAMILY HEALTH HISTORY

Name: ____ Date: ____________________

Select all choices that apply to your family (do not include relations by marriage)

	Mother	Father	Siblings	Children	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
If no longer living, please list cause of death								
Arthritis								
Cancer - type								
Depression								
Diabetes								
Headaches								
Heart Attack/Disease								
High Blood Pressure								
Multiple Sclerosis								
Osteoporosis								
Stroke								
Thyroid Disease								

I understand that the information I have provided is current and complete to the best of my knowledge.

____

Signature (Parent or Guardian if necessary)