Pediatric Intake Form

Personal Information

Full Name: _____ Date: _____

Age: _____ Date of Birth: _____ Preferred Name: _____

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

Parents' Name:_____ Phone: _____

Pediatrician: _____ Phone: _____

Purpose of Care

Please answer all questions on behalf of your child if they are not old enough to fill out this form on their own.

What is/are the health condition(s) you are concerned with today?

*Major concern: _____

*Onset: _____

Is this condition (please circle): getting worse constant comes and goes

Is this condition interfering with your (please circle): school sleep daily routine

Have you had this or similar Conditions in the past? _____

Have you been treated by a medical doctor for this condition? _____

If so, where? _____ Results: _____

Have you ever had chiropractic care before? _____

If so, whom? _____ Results: _____

Representative Name: (please print) _____ Relationship:_____

Representative Signature: _____ Date: _____

Informed Consent for Chiropractic Treatments

A patient, in coming to the Doctor of Chiropractic, gives the doctor permission and authority to care for the patient in accordance with chiropractic tests, diagnosis and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problem. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give a chiropractic adjustment, or health care, if he/she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through health care procedures whatever he/she is suffering from: latent pathological defects, illnesses, or deformities which would otherwise not come to the attention of the Doctor of Chiropractic. The patient should look to the correct specialist for the proper diagnostic and clinical procedures. The Doctor of Chiropractic provides a specialized, non-duplicating health service. The Doctor of Chiropractic is licensed in a special practice and is available to work with other types of providers in you heath care regime.

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays on me (or on the patient named below, for whom I am legally responsible) by Select Health and Wellness. and/or other licensed Doctors of Chiropractic who now or in the future treat me while employed by, working or associated with or serving as Select Health and Wellness.
I have had the opportunity to discuss with the Doctor of Chiropractic the nature and purpose of chiropractic adjustments and other procedures.

I have read or have had read to me, the above consent. I have also had the opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient Name: _____ Representative Name: _____

Signature of Representative: _____ Date: _____

Relationship to Patient: _____