Welcome To Wagner Family Chiropractic, S.C. Pediatric Intake Form

Patient Information

Date_____

Patient_____

Address_____

_____
City State Zip

Sex: ☐M ☐F Age_____ Birthdate_____

Weight:_____Height:_____

Patient SS#_____

Names of Parents/Guardians:_____

_____

Whom may we thank for referring you?_____

_____

Doctor Information

Previous Chiropractor_____
Date of Last Visit_____/_____/_____
Reason_____
Name of Pediatrician_____
Date of Last Visit_____/_____/_____
Reason_____

Insurance

Who is responsible for this account?_____

Relationship to Patient_____

Insurance Co._____

Group #_____

Is patient covered by additional insurance? ☐Yes ☐No

Subscriber's Name_____

Birthdate_____SS#_____

Relationship to Patient_____

Insurance Co._____

Group #_____

ASSIGNMENT AND RELEASE

I, the undersigned Certify that I (or my dependent) have insurance coverage with_____ and assign directly to Dr._____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially respondsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____
Responsible Party Signature

_____ _____
Relationship Date

Phone Numbers

Home_____Work_____Ext_____

Best time and place to reach you_____

IN CASE OF EMERGENCY, CONTACT:

Name_____Relationship_____

Home Phone_____

Work Phone_____Ext_____

Accident Information

Is condition due to an accident? ☐Yes ☐No Date____

Type of accident ☐Auto ☐Home ☐Other_____

Have you made a report of your accident?

☐Yes ☐No With Whom?_____

Attorney Name (if applicable)_____

_____

Patient Condition

Purpose For Contacting Us?_____

Other Health Problems_____

Check any of the following conditions your child has suffered from during the Past SIX Months:

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

Number of Doses of Antibiotics Your Child has Taken:

During the Past Six Months_____, Total During His / Her Lifetime_____

Number of Doses of Other Prescription Medications Your Child has Taken:

During the Past Six Months_____, Total During His / Her Lifetime_____ List:_____

Vaccination History_____

Feeding History

Breast Fed ☐Yes ☐No, How Long_____

Formula Fed ☐Yes ☐No, How Long_____ Type_____

Introduced to: Solids at_____Months

Cows Milk at_____Months

Food/Juice Allergies or Intolerances ☐Yes ☐No

List_____

Childhood Diseases

Chicken Pox	☐Yes ☐No	Age_____
Rubella	☐Yes ☐No	Age_____
Rubeola	☐Yes ☐No	Age_____
Mumps	☐Yes ☐No	Age_____
Whooping Cough	☐Yes ☐No	Age_____
Other	☐Yes ☐No	Age_____

Developmental History

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

_____ Respond to sound

_____ Respond to Visual Stimuli

_____ Hold Head Up

_____ Sit Up

_____ Cross Crawl

_____ Stand Alone

_____ Walk Alone

According to the National Saftey 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? ☐Yes ☐No

Explain_____

Is/has your child been involved in any high impact or contact type sports (i.e., Soccer, Football, Gymnastics, Baseball, Cheerleading, Martial Arts, etc.)? ☐No ☐Yes, Time of Involvement_____

_____

Has your child ever been involved in a Car Accident? ☐No ☐Yes, Explain:_____

Has your child ever been seen on an Emergency Basis? ☐No ☐Yes, Explain:_____

Other Traumas not described above? ☐No ☐Yes, Explain:_____

Prior Surgery: ☐No ☐Yes, Explain:_____

First menses: ☐No ☐Yes, Age of:_____

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

AUTHORIZATION FOR CARE OF MINOR

I hereby authorize this office and its Doctors to administer care to my Son / Daughter as they deem necessary. I clearly understand and agree that I am personally responsible for payment of all fees charged by this office.

Signed:_____ Witnessed:_____Date:_____/_____/_____