Nature's Way Chiropractic
Healing the Body the Natural Way

Child Intake (Birth - 8 years)

Personal Information:

Patient Name:_____ Date:_____
Date of Birth:_____ Age:_____ Sex: M F

Parent/Guardian Information:

Name: _____ Relationship: _____
Address: _____ City:_____
State:_____ Zip:_____ Phone: _____
Employer: _____ Phone:_____
Occupation:_____

What is your concern and primary purpose for your visit today?

_____
_____

Has your child had any injuries? If yes, please describe:

_____
_____

Has your child been diagnosed with any conditions? If yes, please describe:

_____
_____

Has your child had any surgeries? If yes, please describe:

_____
_____

Is there anything else you would like me to know?

_____
_____
_____
_____

_____

For children under 1 year old, please answer the following:

How long was labor?_____ How long did you push?_____

How long?_____ APGAR score?_____ Birth Weight?_____

How many weeks of gestation at delivery?_____

Has the child been reaching developmental milestones? Yes No

Delivery Method? _____

Any issues during birth/delivery?_____

_____

_____

Breast or Bottle fed? Any issues with eating?_____

_____

Patient Informed Consent:

I _____, the undersigned, consent to the treatment(s) of my child provided by this clinic. I understand that my child's condition may necessitate modifications from time to time of the type of treatment(s) rendered and the portions of my child's body that may need to be examined. I understand and consent to clinic staff providing me/child with verbal descriptions, when there are changes to the exam(s) and treatment(s), consent to the clinic staff providing said treatment(s) an exam(s) and hereby consent to any similar subsequent treatment(s) or exam(s). If I or my child do not consent, I will immediately inform clinic staff. There are times when individuals other than staff may see my child receive treatment at the clinic or overhear discussions of my child's condition or insurance. I consent to others perceiving these interactions at the clinic. If additional privacy is required, I will inform the clinic staff.

Parent/Guardian Signature:_____ Date:_____