Liberty Park Chiropractic

PEDIATRIC INTAKE FORM

(Patients 12 and under)

Date: _____

Patient First Name: _____ MI: ____ Last Name: _____ Nickname: _____

Date of Birth: _____ Gender: □ Male □ Female Ethnicity: _____ Hispanic: □ Yes □ No

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

Parent or Guardian Name: _____ Relationship: _____

Cell Phone: _____ Email Address: _____

Preferred Method of Contact: □ Cell □ Email □ Mail Permission to text regarding Patient Appointments? □ Yes □ No

Person Financially Responsible if different than above:

Name: _____ Relationship: _____ Phone #: _____

Address: _____ Do they know Patient is seeking care with us? □ Yes □ No

Health History

Has your child received Chiropractic Care in the past? □ **Yes** □ **No** When Approx? _____ Why? _____

Primary reason(s) for seeking Chiropractic Care with our office: _____

_____

Have they seen anyone else for this condition? □ **Yes** □ **No** When Approx? _____ Who? _____

Past Health History (Check any of the following conditions your child has suffered from during the last 6 months:

□ **Ear Infections**	□ **Scoliosis**	□ **Seizures**	□ **Chronic Colds**	□ **Headaches**
□ **Asthma/Allergies**	□ **ADHD**	□ **Colic**	□ **Rubella**	□ **Recurring Fevers**
□ **Back Pain**	□ **Mumps**	□ **Chicken Pox**	□ **Bed Wetting**	□ **Car Accident DOI: _____**
□ **Digestive Issues**	□ **Temper Tantrums**		□ **Whopping Cough**	□ **Other: _____**

Please list any other conditions/issues your child has experienced in the last 6 months: _____

_____

Current Medications or Supplements: _____

Anything else you want the Doctor to know about your child: _____

_____

I hereby authorize Liberty Park Chiropractic and it's Doctor(s) to administer care as they deem necessary for my child. I also verify that the above information is true and accurate.

Parent or Guardian Signature: _____ Date: _____

Parent or Guardian Printed Name: _____ Relationship: _____