**Pediatric Intake (Ages 0-2 years)**

Date: Referral : 6 digit arrival code:

**PATIENT DEMOGRAPHICS**

Child’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthdate: \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_ Age: \_\_\_\_\_ ⭘ Male ⭘ Female

Birth Height: \_\_\_\_\_\_\_\_\_\_\_ Birth Weight: \_\_\_\_\_\_\_\_\_\_\_ Current Height: \_\_\_\_\_\_\_\_\_\_\_ Current Weight: \_\_\_\_\_\_\_\_\_\_\_

Birth Location: ⭘ Home Birth ⭘ Birth Center ⭘ Hospital ⭘ Birth Provider: Midwife ⭘ OBGYN \_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

­­­­Guardian 1 Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthdate: \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_

Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Permission to share medical information (please check) ⭘

Pediatrician/MD: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City/State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last Visit Date: \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_ Reason for visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CHILD’S CURRENT PROBLEM**

Purpose of this visit: ⭘ Wellness Check-up ⭘ Injury or Accident ⭘ Other

Please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If your child is experiencing **pain/discomfort, please identify where and for how long:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. When did theproblem first begin? Date: \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_ ⭘ Unknown ⭘ Gradual ⭘ Sudden
2. Has this problem occurred before? ⭘ No ⭘ Yes If yes, when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Any bowel or bladder problems since this problem began? ⭘ No ⭘ Yes **If yes,** describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Have you seen any other doctors for this problem? ⭘ No ⭘ Yes **If yes**, whom? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. How long ago? \_\_\_\_\_ Days \_\_\_\_\_ Weeks \_\_\_\_\_ Months \_\_\_\_\_ Years
3. What were the results of past treatment? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. How is this problem NOW?

⭘ Rapidly Improving ⭘ Slowly Improving ⭘ About the Same ⭘ Gradually Worsening ⭘ On and Off

1. Please list any medication(s) taken for this problem: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Has your child ever sustained an injury in an auto accident? ⭘ No ⭘ Yes **If yes,** please explain:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HAS YOUR CHILD EVER SUFFERED FROM** - *Check all that apply*

⭘ Headaches ⭘ Orthopedic Problems ⭘ Digestive Disorders ⭘ Behavioral Problems

⭘ Dizziness ⭘ Neck Problems ⭘ Poor Appetite ⭘ ADD/ADHD

⭘ Fainting ⭘ Arm Problems ⭘ Stomach Aches ⭘ Ruptures/Hernia

⭘ Seizures/Convulsions ⭘ Leg Problems ⭘ Reflux ⭘ Muscle Pain

⭘ Heart Trouble ⭘ Joint Problems ⭘ Constipation ⭘ Growing Pains

⭘ Chronic Earaches ⭘ Backaches ⭘ Diarrhea ⭘ Asthma

⭘ Sinus Trouble ⭘ Poor Posture ⭘ Hypertension ⭘ Walking Trouble

⭘ Scoliosis ⭘ Anemia ⭘ Colds/Flu ⭘ Sleeping Problems

⭘ Bed Wetting ⭘ Colic ⭘ Broken Bones ⭘ Fall off swing.

⭘ Fall in baby walker ⭘ Fall from bed or couch ⭘ Fall from crib ⭘ Fall down stairs.

⭘ Fall off bicycle ⭘ Fall from highchair ⭘ Fall off slide.

⭘ Fall from changing table ⭘ Fall off monkey bars ⭘ Fall off skateboard/skates.

⭘ Allergies to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

⭘ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Financial Agreement**

I hereby authorize payment to be made directly to Core Chiropractic for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application, or copies thereof, for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to Core Chiropractic for all services I receive at this office.

I hereby acknowledge that when given my insurance estimation of cost at the beginning of my care, I am aware that the cost of services could be higher than what estimated by my insurance company and will be my responsibility. Even if your insurance is in network, your insurance may only cover acute care. If you are coming for maintenance care, your insurance may deny coverage, resulting in you paying our time-of-service price.

“No Show” shall mean any patient who fails to arrive for a scheduled appointment. “Same Day Cancellation” shall mean any patient who cancels an appointment less than 24 hours before their scheduled appointment. Core Chiropractic Clinic’s goal is to provide excellent care to each patient in a timely manner. If it is necessary to cancel an appointment, patients are required to call or leave a message at least 24 hours before their appointment time. Notification allows the practice to better utilize appointments for other patients in need of prompt medical care. Appointments must be cancelled at least 24 hours prior to the scheduled appointment time. b. In the event a patient arrives late as defined by “late arrival” to their appointment and cannot be seen by the provider on the same day, they will be rescheduled for a future clinic visit, if available. If appointments are not yet available for their provider, a reminder will be placed for the patient to call to make a future appointment once the schedule opens. c. In the event a patient has incurred three (3) documented “no-shows” and/or “same-day cancellations,” the patient will be subject to the charge of $40.00.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_/\_\_\_\_/\_\_\_\_ **🗀** *Witness Initials*

Patient or Authorized Person’s Signature Date

**Informed consent: X-rays, Imaging Studies, Chiropractic Adjustments, Modalities, and Therapeutic Procedures:**

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risks are such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke-which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments. Treatment objectives, as well as the risks associated with chiropractic adjustments and all other procedures provided at have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, or techniques the doctor deems necessary to treat my child’s condition at any time throughout the entire clinical course of their care.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_/\_\_\_\_/\_\_\_\_ **🗀** *Witness Initials*

Patient or Authorized Person’s Signature Date