

Pediatric Patient Information

Child's Full Name: _____

DOB: ____ / ____ / ____ Age: ____

Gender: Male Female Other

Address: _____

City: _____ State: ____ Zip: _____

Phone: _____ You may leave a voicemail and/or send text reminders to
this number Email: _____

Parent/Guardian #1: _____ Relationship: _____

Phone: _____ Email: _____

Parent/Guardian #2: _____ Relationship: _____

Phone: _____ Email: _____

Emergency Contact (other than parent): _____

Relationship: _____ Phone: _____

Insurance Information (if applicable)

Insurance Company: _____

Policy # / Member ID: _____ Group #: _____

Primary Policy Holder: _____ DOB of Policy Holder: ____ / ____ / ____

Birth & Development History

Birth Type: Vaginal Cesarean Complications: No Yes: _____

Weight: ____ lbs. ____ oz Length: ____ in

Premature? No Yes, by ____ weeks

Milestones (check if delayed): Rolled over Sat Crawled Walked Spoke

Current Health Concerns

Reason for today's visit: _____

When began: _____ Injury/Trauma? No Yes: _____



Symptoms: Pain Limited movement Headaches Posture issues
 Other: _____

Past Health History

Childhood illnesses: Asthma Ear infections Allergies Colic Reflux
 Other: _____

Hospitalizations/Surgeries: _____

Previous chiropractic care? No Yes — When: _____

Daily Activities & Lifestyle

Sports/Activities: _____

Sleep (hrs/night): _____ Screen time/day: _____ hrs

Authorization & Signature

I certify the above information is true to the best of my knowledge. I authorize the release of any medical information necessary to process insurance claims. I understand that I am financially responsible for all charges whether or not paid by insurance.

Parent/Guardian Signature: _____ Date: ____/____/____

HIPAA Privacy Acknowledgement

I understand this office follows applicable privacy laws to protect my child's health information. I acknowledge that I have been informed of my right to review the full Privacy Practices policy (HIPAA Notice) and that a copy is available upon request.

Parent/Guardian Signature: _____ Date: ____/____/____

Consent to Treat a Minor

I hereby request and consent to chiropractic evaluation and treatment of my child by the doctors of this clinic and their staff. I understand that chiropractic care, like all forms of health care, carries some risks, including but not limited to soreness, muscle strain, and in rare cases, more serious complications. I have discussed these risks and had all my questions answered.

I affirm I am the parent or legal guardian of the above-named child and have the legal right to consent to their care.

Parent/Guardian Signature: _____ Date: ____/____/____