Advanced Chiropractic
2 Lee St. Ste C
Newnan, GA 30263
o. 770.253.5040
f. 678.854.7018

ADVANCED CHIROPRACTIC
Health & Wellness Center

New Patient Pediatric Intake Forms

Personal Information

Name (First & Last): ____ Date: _______/________/_______

Date of Birth: _______/_______/_______ Age: _____ Sex (Circle one): Male / Female

Address: ____ Apt: ____________

City: ________________________ State: ____________ Zip: ______________ Country: _____________________

Mother/Father Name: ___________________________ DOB: ___/___/___ Cell Phone: (_______)______-_______

Mother/Father Name: ___________________________ DOB: ___/___/___ Cell Phone: (_______)______-_______

Email Address: ____

How did you hear about us? ☐Family/Friend/Co-Worker?: ____

☐Facebook ☐Instagram ☐Google ☐Drive by ☐Insurance ☐Other: ____________________________________

Child's Current Problem

Purpose for this visit? ☐Wellness Check-Up ☐Injury or Accident ☐Other

Please specify: ____

Is your child experiencing any pain or discomfort? ☐Yes ☐No

If yes, where is the pain or discomfort? ____________________________ How long? _________________________

When did the condition first begin? Date: ___/___/___ ☐Unknown ☐Gradual ☐Sudden

Has your child had this condition before? ☐No ☐Yes If yes, when? ______________________________________

Any bowel or bladder problems since this condition began? ☐No ☐Yes

If yes, please describe: ____

Have you seen any other doctors for this condition? ☐No ☐Yes

If yes, Doctor's Name: __________________________ Date of last visit: ___/___/___

What were the results of the last treatment? ____

How is the condition now? ☐Rapidly Improving ☐Slowly Improving ☐About the Same ☐Gradually Worsening ☐On & Off

Please list any medication taken for this condition: ____

____

Does your child play any organized sports? ☐No ☐Yes

If yes, please specify: ____

Has your child sustained an injury while playing a sport? ☐No ☐Yes

If yes, please explain: ____

Has your child ever been in an auto accident? ☐No ☐Yes

If yes, please explain: ____

Check All That Your Child Has Suffered From:

☐Add/ADHD	☐Colic	☐Fall from changing table	☐Headaches	☐Poor posture
☐Anemia	☐Colds/Flu	☐Fall from highchair	☐Heart trouble	☐Ruptures/Hernias
☐Arm problems	☐Constipation	☐Fall in baby walker	☐Hypertension	☐Reflux
☐Asthma	☐Diarrhea	☐Fall off bicycle	☐Joint problems	☐Scoliosis
☐Backaches	☐Digestive disorders	☐Fall off monkey bars	☐Leg problems	☐Sinus trouble
☐Bed wetting	☐Dizziness	☐Fall off skateboard/skates	☐Muscle pain	☐Seizures/Convulsions
☐Behavioral changes	☐Fall down stairs	☐Fall off swing	☐Neck problems	☐Sleeping problems
☐Broken bones	☐Fall from bed	☐Fainting	☐Orthopedic problems	☐Stomachaches
☐Chronic earaches	☐ Fall from crib	☐Growing pains	☐Poor appetite	☐Walking troubles

☐Allergies: ____ ☐Other: ____

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Child's Name: _________________________________ Date: ___/___/___

___ I understand that I am directly and fully responsible to Advanced Chiropractic Health & Wellness Center for all fees associated with chiropractic care my child receives.

The risks associated with exposure to ionization and spinal adjustment have been explained to me to my complete satisfaction, and I have conveyed my understanding of these risks to the doctor. After my careful consideration, I do hereby request and authorize imaging studies and chiropractic adjustments for the benefit of my minor child for whom I have the legal right to select and authorize health care services on behalf of.

___ Under the terms and conditions of my divorce, separation, or other legal authorizations, the consent of a spouse/former spouse or other guardian is not required. If my authority to so select and authorize the care should change in any way, I will immediately notify this office.

____ ____________________
Parent or Legal Guardian's Signature Date

____ ____________________
Doctor's Signature Date

I, _________________________________ authorize the following person below to bring my child to Advanced Chiropractic Health & Wellness Center for any care or adjustments that have been determined by the doctor:

First & Last Name: ____

Relationship to Child: ____

Parent or Guardian Signature: __________________________________ Date: ___/___/___