Burtis Chiropractic Center

Child Under 2 Intake

Patient Information: Date: ____________

First name: ________________ Middle: ______________ Last: ____________________

Address: ____

City: ______________________________ State: ____________ Zip: ______________

Date of Birth: ____/____/________ Gender: M [ ] F [ ] SSN: ____-____-______

Parent/Guardian Information:

Name: ____________________________________ Phone: ____________________

Name: ____________________________________ Phone: ____________________

E-mail: ____________________________ I consent to receive text/email reminders: [ ] Y [ ] N

How did you hear about our office?

[ ] Facebook/Instagram [ ] Drove by the office
[ ] Advertisement [ ] Referral - Who referred you: ____________
[ ] Google search [ ] Other: ____________

Previous Chiropractic Care

Has your child had previous Chiropractic Care? [ ] Y [ ] N

If yes, reason for visit: ____

Doctor's name: ______________________ Date of last chiropractic visit: ______________

Present Complaint: ____

When did this begin? ______________________ Was there an accident/injury? [ ] Y [ ] N

Has your child had any past treatment for this complaint? [ ] Y [ ] N Describe: ______________

Current medications: ____

General and Prenatal Questions:

Any complications during pregnancy? [ ] Y [ ] N Describe: ______________________

Medications taken during pregnancy: ______________________________________

Cigarettes or alcohol during pregnancy? [ ] Y [ ] N

Birth intervention: [ ] Forceps [ ] Vacuum [ ] C-Section [ ] Other

Complications during delivery? [ ] Y [ ] N Describe: ______________________

Genetic disorders or disabilities: ______________________________________

How many times has your child been prescribed antibiotics in the last 6 months: ______ Lifetime: ______

Has your child received vaccinations? [ ] Y [ ] N

Feeding History:

Breast fed? [ ] Y [ ] N How long: ____________

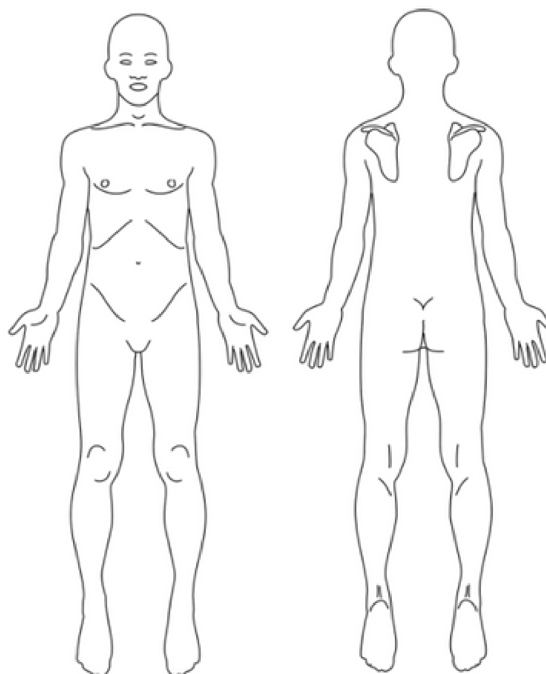
Formula fed? [ ] Y [ ] N How long: ____________

Introduced to: Solid foods at: ______ months

Cow's milk at: ______ months

Food allergies/intolerance? [ ] Y [ ] N List: ______________________________

Please identify problem areas on the image to the right.



Check any of the following that apply:

[ ]Ear infections
[ ]Allergies
[ ]Colic
[ ]Reflux
[ ]Autism/spectrum
[ ]Seizures
[ ]Scoliosis
[ ]Digestive problems
[ ]Tonsillitis
[ ]Developmental delays
[ ]Asthma
[ ]Chronic colds
[ ]ADD/ADHD
[ ]Constipation
[ ]Sleep issues
[ ]Recurring fevers
[ ]Temper tantrums
[ ]Eczema/Psoriasis
[ ]Diarrhea
[ ]Nursing/latching issues
[ ]Other: ______________

Authorization

I certify that I am the parent or legal guardian listed below. I understand the information given on this intake form is true and accurate to the best of my knowledge. I consent to the collection and use of that information to this office of chiropractic. I authorize this office and its staff to examine and treat my child's condition as the doctors see fit. I hereby authorize the doctor to release all information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursement of charges incurred by me. I grant the use of my signed statement of authorization with my signature for required insurance submissions. I understand and agree that all services rendered will be charged to me, and I'm responsible for payment in full for all services unless other arrangements have been made with the business manager. If my account is not paid within 90 days of the date of service and no financial arrangements have been made, I will be responsible for any expense incurred in collecting my account. If my bill becomes delinquent and you have to employ an outside agent to collect the bill, all collection expenses will become my responsibility. I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and me. I understand that if my account is inactive for 18 months any credit balance under the amount of $20.00 will not be reimbursed.

By signing below I agree with this statement of authorization.

Name of Patient (Print): ____
Name of Parent/Guardian (Print): ____________________________________
Parent/Guardian Signature: ____ Date: _____________

By signing below I authorize Dr. Scott Burtis to administer treatment as he deems necessary, even in the absence of a legal guardian to my child. (In cases where another family member/friend might bring the patient into our office.)

Name of Patient (Print): ____
Name of Parent/Guardian (Print): ____________________________________
Parent/Guardian Signature: ____ Date: ____________