Kellie C. Baxter, DC • Specializing in Chiropractic & Injury
6875 Hickory Road Suite 110 • Woodstock, GA 30188
t. 770.345.1111 • f. 770-345-1788 • ReviveWoodstock.com

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HEALTH CENTER

New Patient Pediatric Intake Forms

Personal Information

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

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

Address: ____

City: ___________________________________ State: __________________ Zip: _________________________

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:______________________________

What is the primary complaint: ____

When did the condition first begin? Date: _____/_____/_____ Was the onset [ ]Gradual [ ]Sudden [ ]Unknown

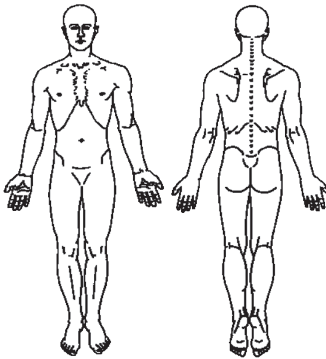
Is the pain is worse in the [ ]Morning [ ]Evening [ ] Can't tell a difference

Frequency you experience this symptom? [ ]Constant [ ]Frequent [ ]Intermittent [ ]Occasional

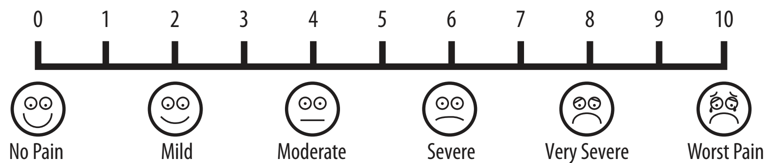
Describe the pain (How does it feel?) [ ]Numb [ ]Tingling [ ]Stiff [ ]Aching [ ]Stabbing [ ]Throbbing [ ]Dull [ ]Burning

Does the pain shoot or radiate to another area of your body? [ ]No [ ]Yes If yes, location:__________________________

Please circle all areas where you are experiencing symptoms on the figures to the right.



Please rate the intensity of your pain using the scale below.
Circle the number that best describes your pain.



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: ____________________________

Please list any medications your child is taking:____

Please list any surgeries your child has had:____

Please list any family (hereditary) history concerns:____

Has your child been vaccinated? [ ]No [ ]Yes [ ]As Scheduled [ ]Delayed Schedule

Has your child had [ ]Chicken Pox [ ]Mumps [ ]Measles [ ]Rubella [ ]Rubeola [ ]Pertussis / Whooping Cough

_______*Doctors Initials Kellie Baxter, DC*

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

Check All Childhood Diseases or Illnesses That Your Child Has Suffered From:

[ ]ADD/ADHD	[ ]Colic	[ ]Headaches	[ ]Poor Posture	[ ]Hernias
[ ]Anemia	[ ]Colds/Flu	[ ]Heart trouble	[ ]Reflux	[ ]Scoliosis
[ ]Arm problems	[ ]Constipation	[ ]Hypertension	[ ]Sinus trouble	[ ]Seizures
[ ]Asthma	[ ]Diarrhea	[ ]Joint problems	[ ]Sleeping issues	[ ]Stomach aches
[ ]Back aches	[ ]Dizziness	[ ]Digestive disorder	[ ]Bed wetting	[ ]Leg problems
[ ]Behavior changes	[ ]Fractures	[ ]Chronic ear infection	[ ]Fainting	[ ]Muscle pain
[ ]Neck pain	[ ]Torticollis	[ ]Poor appetite	[ ]Walking issues	[ ]Growing pains
[ ]Diabetes	[ ]Recent falls	[ ]Delayed speech	[ ]Paralysis	[ ]Juvenile Rheumatoid Arthritis

To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my childs health concern. Parent /Ward Signature:___________________________________Date:_________________

Personal History

Illnesses:____

____

Allergies: [ ]No [ ]Yes If yes, please check all that apply: [ ]Seasonal [ ]Food___________ [ ] Other_______________

Please check any of the following treatments you are currently having:
[ ]Massage Therapy [ ]Physical therapy [ ] Acupuncture [ ]Chemotherapy [ ]Dialysis [ ]Blood transfusions [ ]Herbs
[ ]Hormone replacement therapy [ ]Birth control [ ]Infusions [ ]IV Vitamin therapy [ ]Essential oils [ ]Homeopathy
Please list any prior injuries / concussions / fractures / accidents / hospitalizations: _______________________________

____

____

Acknowledgements /Agreement

Initials_______*FEMALES ONLY* I realize that x-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge that I am not pregnant. Date of last menstrual period (_____/_____/_____)

Initials_______I grant permission to be called to confirm or reschedule an appointment and be sent occasional cards, letters, emails or health information to me as an extension of my care in this office.

Initials_______To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresnted the presence, severity or cause of my health concern.

_______*Doctors Initials Kellie Baxter, DC*

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

Consent Form for Treatment of Minor Child:

I understand that I am directly and fully responsible to Revive Health Center for all fees associated with chiropractic care my child receives. I hereby request and consent to the performance of chiropractic procedures, various forms of physio-therapy, physical examination, x-ray studies, and/or any clinical services that are deemed necessary in my childs case to be administered by the doctor and/or any support staff employed or contracted by this office or clinic. I understand that, as with any health care procedure, complications are possible following chiropractic manipulation and/or manual therapy techniques. There are some risks to treatment, including, but not limited to, muscle spasms, aggravating and /or temporary increase in symptoms, lack of improvement of symptoms, fracture, disc injury, stroke, dizziness, headaches, discolorations, burns with modalities, and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, and is in my childs best interests. I understand that Chiropractic adjustments and supportive treatment is designed to reduce and/or correct subluxations, allowing the body to return to improved health. It can also be used to alleviate other symptoms through a conservative approach with hopes to avoid more invasive procedures. I have had the opportunity to discuss with the doctor of chiropractic named below and / or with other office or clinic personnel the nature and purpose of chiropractic adjustments and procedures. I further understand that, as with all healthcare treatments, results are not guaranteed and there is no promise to cure. I hereby acknowledge that if I do not keep my childs appointments as recommended to me by treating doctor, he/she has the right to terminate responsibility for my care and relinquish any disability granted to me within a reasonable period of time. I further understand that there are other treatment options available for my childs condition, and that I have the right to a second opinion should I have concerns as to the nature of my examination from any other doctor. I will notify the facility/physician immediately. I understand that failure to do so may jeopardize my case. I understand the risks associated with exposure to ionization and do hereby request and authorize imaging studies if needed for the benefit of my minor child for whom I have the legal right to select and authorize health care services on behalf of.

I, ____________________________________ (print) have read, or had read to me, the above consent and I have had an opportunity to ask questions regarding its content. By signing below, I agree to the above-named procedures on my child and I intend this consent form to cover my child's entire course of treatment for my child's present condition and for any future condition(s) for which I seek treatment for my child with this office.

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.

Patient or Guardian Signature: X____ Date: __________________

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

First & Last Name: _____________________________________Relationship to Child: _____________________________
Parent or Guardian Signature: ____ Date: _____/_____/______

Consent for Child of driving age to bring himself / herself to scheduled appointments:

I,____, hereby authorize my child of driving age to bring him / herself for his/her scheduled appointments after discussing and agreeing to a scheduled treatment plan and frequency with the doctor.

First & Last Name: _____________________________________Relationship to Child: _____________________________
Parent or Guardian Signature: ____ Date: _____/_____/______