Kellie C. Baxter, DC • Specializing in Chiropractic & Injury
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revive 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: _____
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? _____
Have you seen any other doctors for this condition? [ ]Yes [ ]No If yes, Doctor's Name: _____
Date of last visit: ___/___/___ What were the results of the last treatment? _____
How is the condition now? [ ]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: _____
Does your child have allergies? [ ]No [ ]Seasonal [ ]Food _____ [ ]Medication_____
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

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:_____

_____*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: _____/_____/_____