

Pediatric Patient Intake Form

**Klug Chiropractic 715-832-2292
2130 Brackett Ave. Eau Claire WI 54701
James Klug DC | Heather Mickelson DC**

CASH / INSURANCE COMPANY NAME _____

PATIENT INFORMATION

CHILDS NAME: _____ BIRTHDAY: ____ / ____ / ____ AGE: ____

GENDER: MALE / FEMALE AGE: ____ HEIGHT: _____ WEIGHT: ____ SSN: _____

COMPLICATIONS DURING PREGNANCY: Y / N PREMATURE DELIVERY: Y / N

REFERRED BY: INTERNET / FAMILY / FRIEND NAME: _____

PREVIOUS CHIROPRACTIC CARE: Y / N APPROX DATE: _____ WHERE: _____

EMERGENCY CONTACT: _____ PHONE: _____

PARENT / INFORMATION

PARENT / GUARDIAN NAME(S): _____

ADDRESS: _____ CITY: _____ STATE: ____ ZIP CODE: _____

HOME PHONE: _____ CELL: _____ WORK: _____

EMAIL: _____

CONDITION INFORMATION

REASON FOR VISIT: _____

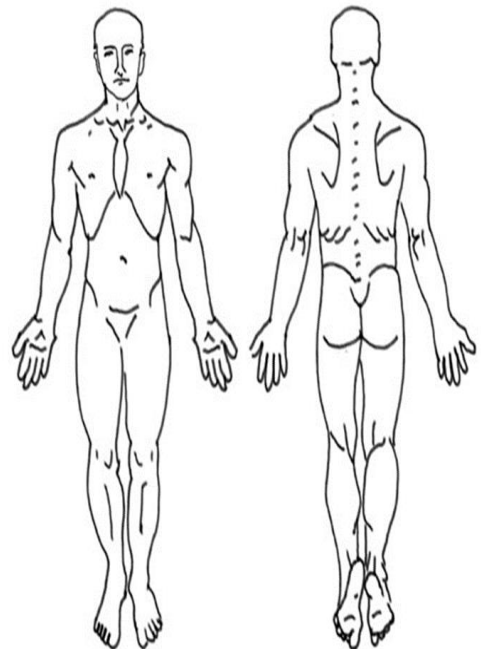
ACCIDENT/TRAUMA: Y / N SURGERIES: Y / N SPORTS INJ: Y / N

IF YES, SPECIFY: _____

DATE SYMPTOMS STARTED: _____

PARENT / GUARDIAN _____

I give my permission to Dr. James A. Klug / Dr. Heather Mickelson, of Klug Chiropractic, to evaluate and treat my child/minor, and bill services to the Insurance Company listed above. I also acknowledge that I am responsible for any deductibles, co-ins., or other charges incurred for the above named child/minor, which are not paid for by insurance.



Parent / Guardian Signature: _____

Date: ____ / ____ / ____