Pediatric (Ages 0-12) Patient Intake Form

Klug Chiropractic 715-832-2292

2130 Brackett Ave. Eau Claire WI 54701

James Klug DC

CASH / INSURANCE COMPANY NAME ______________________________ Date ____/____/________

PATIENT INFORMATION

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

GENDER: MALE / FEMALE HEIGHT: ___________ WEIGHT: _________

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: _____________________

SOCIAL SECURITY: ___________________________

EMAIL: ____

CONDITION INFORMATION

REASON FOR VISIT: ____________________________________

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

IF YES, SPECIFY: _______________________________________

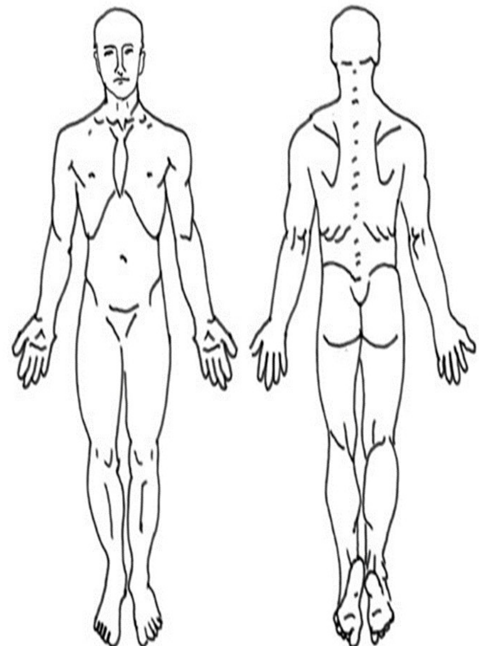
____

DATE SYMPTONS STARTED: _______________________________

PARENT / GUARDIAN_________________________________

I give my permission to Dr. James A. Klug 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.

PLEASE CIRCLE WHERE IT HURTS BELOW:



Parent / Guardian Signature:

___________________________________ Date: ______ / ______ / ________