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

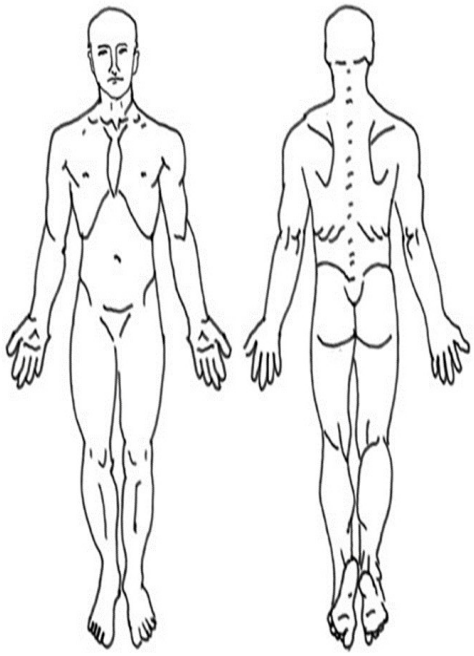
PARENT / GUARDIAN NAME(S): _____

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

HOME PHONE: _____ CELL: _____ WORK: _____

EMAIL: _____

PLEASE CIRCLE WHERE IT HURTS BELOW:



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.

Parent / Guardian Signature:

_____ Date: _____ / _____ / _____