Child/Infant New Patient Intake Form

Patient Information

Date_____

Patient Name_____

Address_____

City_____State_____ Zip Code_____

Phone #_____

Email_____DOB_____

In Case Of Emergency

Name_____

Relationship_____ Phone Number_____

Insurance Information

Insurance Company_____

Insurance ID #_____

Insurance Group #_____

Insurance Subscriber Information

Name_____

Birthdate_____Relationship to Patient_____

Description of Presenting Symptoms

Reason for Visit_____

Where are your symptoms?_____

When did your symptoms begin?_____

How did you injure yourself?_____

Type of Pain (circle)

Aching Burning Cramping Dull Inflamed Numbness Sharp Shooting Stiffness Throbbing Tingling

On a Scale from 0-10, with 10 being the worst, what is your pain level?_____

Is the Pain/Injury stopping you from doing anything?_____

What are your goals from care_____

Who has treated you for this condition?_____

_____

Have you had an X-Ray, MRI, CT Scan, or EMG in the last year?_____

If yes, Where?_____

Health History

Injuries/Surgeries	Description	Date
Ear Infections		
Illnesses		
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		
Hospitalizations		
Rounds of Antibiotics		

Please List Current:

Medications

Supplements

Allergies

I _____ make oath and say that I am the lawful guardian of the child listed within this paperwork. I hereby authorize **Savino Chiropractic PLLC** to treat my child, _____ .

Guardian Signature_____

Guardian Name Printed_____

Date_____

Cancellation Policy

If you are unable to keep a scheduled appointment, 24 hours advanced notice is required for both canceling or rescheduling appointments. If less than 24 hours notice is given or you miss your appointment, you will be charged $40.

Thank you for understanding our policy.

Patient Signature_____

Printed Name_____

Date_____