Today's Date (month/day/year): _____/_____/_____
Z#: _____

PATIENT INTAKE FORM: PEDIATRIC

CONTACT INFORMATION:

First Name: _____ Middle Name: _____ Last Name: _____

Address: _____

City: _____ State: _____ Zip: _____

SS#: _____-_____-_____ DOB: ____/____/_____ Age:_____

Please circle one: Gender: M F Current Height:_____ Current Weight:_____

Name of Parents/guardians:_____

Home Phone #: (____)_____-_____ Cell #: (____)_____-_____ Work Phone #: (____)_____-_____

Contact Preference:_____ Do you want text reminders for your appointments?_____

E-mail of parent/legal guardian: _____
How did you hear about our office OR who referred you? _____

Emergency Contact: _____ Relationship: _____ Ph: (_____)_____-_____

Do we have permission to discuss scheduling/appointments with emergency contact? Yes or No

Do we have permission to discuss financial amount owed or credit with emergency contact? Yes or No

PEDIATRICIAN:

First Name: _____ Last Name: _____ Group: _____

Doctor's Address: _____ City: _____

State: _____ Zip: _____ Date of last visit (M/D/Y):_____

Are you satisfied with the care your child has received there? (circle one) YES or NO

Purpose of Visit?_____

_____

Other chiropractors/doctors seen for this condition:

1._____ 3._____

2._____ 4._____

Other Health Problems?_____

Circle any of the conditions that your child has suffered from in the past 6 months:

Ear Infections Scoliosis Seizures Chronic Colds Headaches Asthma/Allergies

Digestive Problems Colic ADHD Growing Pains Recurring Fevers Bed Wetting

Number of doses of antibiotics your child has taken:

During the past 6 months:_____ Total over lifetime:_____

Number of Medications your child has taken:

During the past 6 months:_____ Total over lifetime:_____

Vaccination History (circle all that apply)

Hepatitis B DPT (Diphtheria, Pertussis, Tetanus) Haemophilus Influenza Polio

MMR(Measles, Mumps, Rubella) Varicella (chicken pox) COVID

Did your child suffer any adverse reactions following immunizations?_____

Circle any that apply: Fever Vomit Seizure Swelling Lethargy Paralysis Other:_____

PRENATAL HISTORY

Name of Obstetrician/Midwife?_____

Complications during pregnancy?_____

Medications during pregnancy?_____

Cigarette/Alcohol use during pregnancy?_____

BIRTH HISTORY

Birth place (circle one): Hospital Home Birthing Center

Birth Intervention: Forceps Vacuum Extraction Caesarian Section (Planned or Emergency?)

Birth Weight: _____ Birth Length: _____ APGAR: _____

FEEDING HISTORY

Circle any that apply: Breast Fed Formula Fed How long? _____

Food/Fluid Intolerances?_____

DEVELOPMENTAL HISTORY

It is important to know if your child reach his/her milestones on time? At what age did your child:

Respond to sound_____ Respond to Visual Stimuli_____ Hold Head Up_____

Cross Crawl_____ Stand _____ Walk _____

According to the National Safety Council, approximately 50% of children fall head first from a high place during their first year of life (i.e. a bed, changing table, down stairs). Was this the case with your child? (circle one) Yes OR No

Has your child been involved in any high impact or contact sports (i.e. soccer, football, wrestling, gumnastics, cheerleading, karate)?

_____

Has your child been involved in a motor vehicle accident? Yes OR No If yes, when?_____

Has your child been seen on an emergency visit? Yes OR No If yes, for what?_____

Has your child undergone any surgery? Yes OR No If yes, for what? _____

At what age did your child contract the following: Chicken Pox _____ Mumps _____ Rubella _____

Whooping Cough _____ Other: _____

Authorization for care of minor

I hereby authorize Dr. John Jarosz to administer chiropractic care to my son/daughter as he deems necessary. I clearly understand and know that I am personally responsible for payment of all fees charged by this office. I have been provided a copy of the terms of acceptance, consent to use and disclosure of protected Health Information, as well as appointment policies for this office

_____ _____

Parent/guardian print name Date

_____

Parent/guardian signature

Jarosz Chiropractic, P.C. Wellness Locations:
151 Genesee St. □ New Hartford, NY 13413 □ (315)339-2422
143 N. Washington St Ste 1. □ Rome, NY 13440 □ (315)339-2422

GUARANTOR INFORMATION:

Does your son/daughter have health insurance? • Yes • No *(If yes, go on to the next line)*

Who is responsible for the health insurance? • Patient • Parent/Guardian • Other *(If patient, skip to next section)*

First Name: _____ Middle Name: _____ Last Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone #: (_____)_____-_____ Secondary Phone #: (_____)_____-_____ Cell #: (_____)_____-_____

DOB: ____/____/_____ SS#: _____-_____-_____ Gender: • M • F

INSURANCE INFORMATION: *(If you have health insurance present your benefit card to the front desk staff with this completed form)*