Child Initial Intake Form

Cornerstone Chiropractic Clinic-13470 N 83rd Ave, Ste 302-Peoria, AZ 85381-623-249-7141 Jessica J. Haug DC

Child's Name: _____Date of Birth: _____/_____/_____ Age:_____File #_____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: (____) _____ -_____
Mother's Name: _____ Cell Phone: (____) _____ -_____
Father's Name: _____ Cell Phone: (____) _____ -_____
Pediatrician's Name: _____Clinic Name:_____
Clinic Address: _____Clinic Phone: (____) _____ -_____
May we contact your pediatrician regarding your child's treatment at this office? _____ Yes _____ No

HISTORY OF PRESENT ILLNESS

Purpose of this appointment: ____Wellness Check-up ____Specific
Concern:_____
_____
When did you first notice the problem?
_____
_____
How did it originally occur?
_____
_____
How has it progressed recently? (circle) Same/Improving/Getting Worse
How frequent is the condition? (circle) Constant/Frequently/Intermittent/Occasionally
If your child can describe the pain: (circle all that apply)
Sharp/Dull/Numbness/Tingling/Aching/Burning/Stabbing/Throbbing/Other: _____
Does anything relieve the problem? If so, please list. _____ No _____ Yes:
_____
_____
Does anything make the problem worse? If so, please list. _____ No _____ Yes:
_____
_____
Previous Doctors and treatments for complaint:
_____
_____

Place an "X" on the line below to indicate the level of your problem.
No Symptoms_____**Extreme Symptoms**

_____ Date_____
Guardian Signature