FAIRWOOD
Chiropractic & Physical Therapy

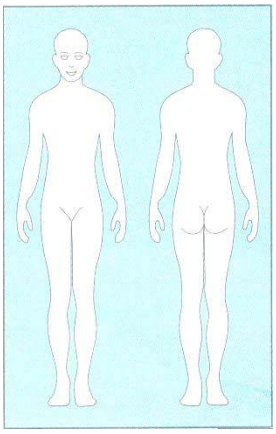
Child (under 18 years of age) Information & Consent Form

Child's Full Name:_____ **Date of Birth:**___/___/_____

Social Security #:_____ **Parent/Guardian Name(s)**_____

Address:_____ **City:**_____

State:_____ **Zip:**_____ **Phone Number:**_____



Health Problem or visit reason? _____

When did the symptoms/ issues appear? _____

Is this condition getting progressively worse? ❑ Yes ❑ No ❑ Unknown

If applicable please mark the body with the symbol X where problems/pains are being experienced.

Was the birth normal? Yes/No If No why?_____

Is there any medication(s) the child is on? Yes /No If yes, what?_____

Has the Child had any surgeries? Yes/No If yes when and where?_____

Additional Comments:_____
_____
_____
_____.

I hereby authorize an office evaluation, examination and x-rays to be performed on my child and certify that I have the legal guardianship to make health decisions on behalf of this child. I authorize the release of any information necessary to process my insurance claims and assign and request payment directly to my physician.

Parent Name:_____

Signature:_____ **Date:**_____