Chiropractic Wellness Centre, PC

James J. Peck, D.C. & Audrey E. Peck, D.C.

191 Chandler Road, Unit B, Andover MA 01810

Phone (978) 655-5217

Minor Intake Form

“Chiropractic is unique and powerful. It is truly a lifestyle and is most effective when used as a process rather than an event.”

Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Minor’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_

Home phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Parent DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Parent DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Names and birthdates of minor’s siblings:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is you and your minor’s lifetime goal for your minor’s health?

Some examples of a lifetime goal are the following –

 “I want my minor to maintain health and energy throughout their life”

 “I want my minor to be able to sleep better at night”

“I want my minor to learn the benefits of a healthy lifestyle from an early age”

Initial Visit Informative History

Whom may we thank for referring you and your minor? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

We look forward to getting to know your minor. Please complete this form as candidly as possible.

What is the reason for your minor’s visit?

Have you or your minor had any previous chiropractic experience? (Check all that apply)

Yes, I have \_\_\_\_\_\_ Yes, My Minor Has\_\_\_\_\_\_\_ No \_\_\_\_\_\_\_\_

Name of chiropractor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How long were you/your minor under care? \_\_\_\_\_\_ days \_\_\_\_\_\_ weeks \_\_\_\_\_\_ months \_\_\_\_\_\_\_\_ years

Date of last visit? \_\_\_\_\_\_\_\_\_\_\_

Why did you/your minor stop?

*“Your health is dependent on your nerve system. For you to function at your best your brain must have clear communication with the rest of your body. This is accomplished through your spinal cord which is protected by your spine. Chiropractors evaluate your spine to determine if there is interference. Interference (subluxation) occurs from stress, either physical (repetitive awkward positions, bumps and bruises), emotional (criticism, exhaustion, rudeness) or chemical (bad foods, drugs, pollution).”*

Physical Trauma:

Any known birth trauma: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List surgeries with dates and reasons: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List fractures or other significant injuries with dates and reasons: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any known allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any known digestive issues: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any other reoccurring health concerns (ear infections, asthma, etc): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any known learning disabilities: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Chemical Trauma:

How many fast food meals does your minor eat per week? \_\_\_\_\_\_\_\_\_\_

Do they consume any artificial sweeteners? Y N (please circle)

Do they take any over the counter drugs? Y N (please circle)

If yes, what do they take? \_\_\_\_\_\_\_\_\_\_\_\_\_ how often? \_\_\_\_\_\_\_ day \_\_\_\_\_\_\_\_\_ week

Do they take any prescription drugs? Y N (please circle)

 If yes, what do your minor take? List with dosage and for how long \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Do they take any supplements? Y N (please circle)

 If yes, please list and how often \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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We here at the Chiropractic Wellness Centre are excited to meet you and your minor. We offer excellent health care and will educate the both of you about the ***seven essentials for health:***

* What your minor eats
* What your minor drinks
* What your minor thinks
* How your minor breathes
* Your minor’s posture
* ***How much & how your minor exercises?*** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* ***How your minor rests/sleeps?*** ***side/back/stomach (please circle)*** ***Number of hours?*** \_\_\_\_\_\_\_\_

Our goal is to improve the health of our community by providing the opportunity for entire families to experience optimum function, and physical, mental and social well-being.

While we hope yo

u will choose our office for the care of your minor, we recognize that it is an individual decision and we will respect you and your minor in the process.

Payment in full ($200.00) is expected on **FIRST VISIT**. This payment includes 1st visit (comprehensive exam and adjustment) and 2nd visit (a ROF and second adjustment). All other fees are to be paid at the time of service until other arrangements have been made and agreed upon in writing.

**PLEASE READ AND SIGN BELOW**

*The information I have provided on this intake form about my minor, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, is true and accurate to the best of my knowledge. I give Dr. James Peck and/or Dr. Audrey Peck permission to render care to my minor today. This initial visit includes a health history/consultation, chiropractic exam/evaluation, and any initial care that is determined to be clinically necessary and mutually agreed upon.*

*I also understand that Chiropractic Wellness Centre, PC is a cash practice (they do not bill any insurance companies) and that I am responsible for full payment for any services that my minor has received and may not submit receipts to my insurance company for any kind of reimbursement.*

Signature of Parent \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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