Frank T. Heresco, D.C., DABCO
Joseph A. Shepro, D.C.
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Heresco Chiropractic

Scoliosis Screenings

Intake Paperwork

Consent to Treatment

Date: ____/____/____

Child's Name: _____ Birthdate: ____/____/____ Age: ___ ❑Male ❑Female

Mailing Address: _____ City, State, Zip: _____

Guardian's Name(s): _____ Relationship: _____

Has the child ever had a scoliosis screening? ❑Yes ❑No If yes, was scoliosis identified? ❑Yes ❑No

Has a family member of the child ever been diagnosed with scoliosis? ❑Yes ❑No

Please list any "major" illnesses: _____

Any daily medications: _____

Child's physicians name: _____ Phone: _____

Consent to Treatment of a Minor- Scoliosis Screening

I, the undersigned, parent/guardian of _____, a minor do hereby authorize consent to the Doctors of Heresco Chiropractic to a scoliosis screening. I understand that results will be mailed to the provided address above if there is suspicion of scoliosis.

This authorization will remain effective until revoked in writing delivered to the Doctors of Heresco Chiropractic.

Parent/Guardian Name (print): _____Date: ____/____/____

Parent/Guardian Signature: _____

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