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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: _____