Serenity Therapeutics LLC
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BIOREGULATION PEDIATRIC INTAKE FORM

(Age 1-17 years)

Today's Date _____

Child's Name _____ Age _____ Birth Date _____

Child's Address _____

Street City State Zip

Accompanying Parent's Name _____ Relationship to Child _____

Child's Primary Care Physician _____Phone _____
Consent to contact Primary Care Physician if needed: **Y** or **N**

Signature: _____ Date: _____

Accompanying Parent's Information:

Parent Name _____

Address _____

Street City State Zip

Best Number to Call _____

Occupation _____ Employer _____

E-mail _____

Person to contact in case of emergency: _____Phone _____

Whom may we thank for referring you? _____

Reason for evaluation_____

Has child ever been previously treated with Bioregulation? _____ If yes, where/when/location?

_____

_____

Number of sessions? _____ Reason for stopping treatment _____

What are your current concerns? _____

_____

Current Medications:

Medication	For Condition	Dose	How long been on

Current Supplements:

Supplement	For Condition	Dose	How long been on

Any current medical problems or recent surgeries?

_____

Are you receiving treatment for any health concerns? ____Yes ____ No If yes, explain _____

_____

If yes, who do you see for these concerns? _____

Please list any past health problems _____

Please list any treatment received for past health problems _____

_____

The information given is correct to the best of my knowledge.

Signature: _____ Date: _____

Print Name: _____ Relationship to patient: _____