Family First Chiropractic

PEDIATRIC INTAKE FORM

Date:______________________________

PATIENT INFORMATION

Child's Name: ______________________________Guardian's Name:____________________________

Address: ______________________________City_______________________Zip: _________________

Home Phone: (   ) _______________________Cell Phone: (   ) ___________________________

Email: ______________________________Birth Date: __________________ Age: _______ Sex: M F

Have you or your child ever had chiropractic care before? Yes No

If yes, please tell us the doctor's name____

Were you pleased with your care? Yes No

Who can we thank for referring you or how did you hear out about us? ___________________________

Is this appointment related to an auto accident? Yes No *(If yes, please fill out auto accident questionnaire)*

Is your child receiving care form other health professionals? Yes No

If yes, please name them and their specialty ____

Who's your family's primary care physician? ____

Please list any drugs or medications your child is taking ____

____

Please list any vitamins/herbs/homeopathics/other your child is taking __________________________

____

Please list any allergies your child has ____

REASON FOR SEEKING CARE

What health challenge brings your child to our office? ____

____

When did symptoms first begin? ___________________ How did it start? Sudden/Gradual/Post-injury

Is this condition: getting worse/improving/intermittent/constant/not sure

What makes the problem better? ____

What makes the problem worse? ____

Has your child had a similar condition? Yes No Please explain ______________________________

Has your child had treatment for this problem before? Yes No Please explain ___________________

____

Does your child eat well? Yes No Does your child have regular bowel/bladder movements? Yes No

Has your child ever been checked for vertebral subluxation? Yes No Not Sure

BIRTH HISTORY

Child's Birth was: At home At a birthing center At a hospital

My obstetrician/midwife/family physician was ______________________________

Child's birth was:

- ☐ Natural vaginal (no medications/interventions)
- ☐ Vaginal with intervention: *please circle all that apply below*
  induction pain medication epidural episiotomy vacuum extraction forceps
- ☐ C-section: scheduled or emergency

Please list reasons for any interventions/complications ______________________________

____

Child's birth weight __________birth height __________current weight __________current height__________

APGAR score at birth __________ APGAR score after 5 minutes __________

Was your child alert and responsive within 12 hours of delivery? Yes No

If no, please explain ______________________________

GROWTH & DEVELOPMENT

At what age did the child: Respond to sound __________ Follow an object__________

Hold head up__________ Sit alone__________ Teethe __________ Crawl __________Walk __________

Hospitalization/Surgical History: (please list below all surgeries and hospitalization, including the year)

____

____

Please list any major injuries, accidents, falls, and/or factures your child sustained in his/her lifetime with year: ______________________________

____

Is/was your child breastfed? Yes No If yes, how long? __________

Formula introduced at age __________ What type? ______________________________

Introduction of cow's milk at age __________ Began solid foods at age __________

Please list any foods/juice intolerance ______________________________

Did mother smoke during pregnancy? Yes No Did mother drink alcohol during pregnancy? Yes No

Any illness of mother during pregnancy? Yes No If yes, please explain including treatments __________

____

List any drugs/medications(including over the counter)taken during pregnancy __________

List any supplements taken during pregnancy ______________________________

GROWTH & DEVELOPMENT CONTINUED

Any exposure to ultrasound? Yes No If so, how many and what was the medical reason? ___________

Any pets at home? Yes No Any smokers at home? Yes No

Has your child received any vaccinations? Yes No If yes, which ones and list any reactions _________

Has your child received any antibiotics? Yes No If yes, how many times and list reason _____________

Any difficulty with breastfeeding? Yes No If yes, please explain ____________________________________

Any difficulty with bonding? Yes No If yes, please explain ____

Any behavioral problems? Yes No If yes, please explain ____

Any night terrors, sleepwalking, or difficulty sleeping? Yes No If yes, please explain ________________

Age child began daycare _____________ Average number of hours of TV per week ______________

Does your child seem normal for his/her age? Yes No If no, please explain _________________________

FAMILY HEALTH HISTORY

Check those involving close family & add identification: M=Mother; F=Father; S=Sibling; G=Grandparents

- ☐ Cancer, type_____________
- ☐ Depression
- ☐ Diabetes
- ☐ Back Problems
- ☐ Heart Disease
- ☐ Liver Disease
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Lung problems
- ☐ Scoliosis
- ☐ Neck Problems
- ☐ Osteoporosis
- ☐ Seizures
- ☐ Osteoarthritis
- ☐ Rheumatoid Arthritis
- ☐ Other ____

CHIROPRACTIC HISTORY

Do you know what a subluxation is? Yes No

Do any of your friends or relatives see a chiropractor? Yes No

If yes, do they use chiropractic for: ☐ Health maintenance/optimization ☐ Health problems ☐ Both

Are you seeking chiropractic for : ☐ Health maintenance/optimization ☐ Health problems ☐ Both

What would you like to gain from chiropractic care? _______________

Are there other health concerns or anything else you'd like us to know about your child? ______________

____

Parent/Guardian Signature Date

PATIENT HIPAA CONSENT FORM

Protecting the privacy of your child's personal health information is important to us. Disclosure of your child's protected health information without authorization is strictly limited to define situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment, or practice operations will be made only after obtaining your consent. You may request restrictions on your disclosures. You may inspect and receive copies of your records within 30 days with a request. In the future, we may contact you for appointment reminders, announcements, and to inform you about our practice and its staff.

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights and privacy regarding my protected health information. I understand that this information can and will be used to: conduct, plan, and direct my treatment and follow up with multiple healthcare providers who may be involved in that treatment directly or indirectly, obtain payment from third party payers, and conduct normal healthcare operations. I have read and understand your Notice of Privacy Practices. A more complete description can be requested. I also understand that I can request, in writing, that you restrict how my personal information is used and disclosed.

Date: ____________________ Print Patient Name: ____

Guardian Signature: _______________________________________Relationship to Patient: ______________________

FINANCIAL POLICY & AUTHORIZATION FOR CARE

Our goal is to provide the highest quality healthcare possible for our patients. In order to achieve this goal, we need your commitment as well.

- We urge our patients to follow the doctor's recommendations for care. Please keep your appointments as scheduled or call our office within 24 hours to make any changes. In order to attain the level of achievement we both desire, care must be followed.
- Family First Chiropractic does not submit to insurance. Understand that you are responsible for payments for care at time of service or in advance. Upon request, you can receive a superbill to submit to your insurance for reimbursement.
- If you have any questions about our financial policies, please ask. If you need to make special arrangements, please ask. We will do everything possible to meet your financial needs.
- *Advanced Beneficiary Notice of NON-Coverage (ABN). Your health insurance does not reimburse for everything, even some care that you or your health care provider have good reason to think you need. We expect your health insurance will not pay for items and services such as your initial visit and any chiropractic care deemed as maintenance or wellness care by your carrier. Signing below signifies that you want these items and services, but understand that they will not be billed to your insurance company. Therefore, you are responsible for payment and cannot appeal to your insurance carrier as they were not submitted and/or billed to them. This notice gives our opinion, not an official Medicare or other insurance carrier's decision. If you have other questions, please ask. Signing below means that you have received and understand this notice*

Date: ________________________Guardian Signature: ____

I hereby authorize doctors and staff at Family First Chiropractic to provide care as deemed appropriate. At Family First Chiropractic, we do not diagnose or treat any disease or condition other than vertebral subluxation and the doctor/clinic will not be held responsible for any pre-existing medical conditions. I certify that the above information is correct to the best of my knowledge. I will not hold the doctor responsible for any errors or omissions that I may have made in the completion of this form. Chiropractic, as well as all other types of health care, is associated with potential risks in the delivery of treatment. While chiropractic treatment is remarkably safe, you need to be informed about the potential risks related to your care to allow you to be fully informed before consenting to treatment. Please inquire if you have further questions. Chiropractic is a system of health care delivery and therefore, as with any health care delivery system, we cannot promise a cure for any symptom, condition, or disease as a result of treatment in this office. An attempt to provide you with the very best care is our goal, and if the results are not acceptable, we will refer you to another provider who we feel can further assist you.

Date: ________________________Guardian Signature: ____