# Pediatric Intake Form (Birth – 12 years)

**Patient Information:** Date: _____________
Child's Name: ________________________________________________ DOB: __________________
Address: ____________________________________________________________________________
Parent/Guardian's Name: _____________________________________________________________
Phone #: ___________________________________________ ( Cell Work Home )
E-mail Address: _________________________________________________________________
Has your child been treated by a Chiropractor? Yes No
If yes, name of office and doctor. _______________________________________________________
Any other forms of treatment? Yes No
If yes, what treatment and when? _______________________________________________________
Any tests performed? X-rays CT Scan MRI Lab Work Other

**Prenatal History:**
Is your child adopted? Yes No
Did you have any complications and when? ______________________________________________
Did you smoke? Yes No
Did you consume alcohol? Yes No
Did you take medication? Yes No
Reason for medication. _______________________________________________________________

**Birth History:**
Place of Birth: Home Birthing Center Hospital
Provider: Midwife OB-Gyn
Type of Birth: Vaginal C-Section
Were pain medications used? Yes No
Was labor induced? Yes No
If yes, why? ____________________________________________________________________
What position did you deliver in? Squatting On back Other
Birth Truama? Doctor Assisted Twisting and/or Pulling Vacuum Extraction Forceps
APGAR score: birth ____/10 5mins ____/10 Unsure
Did you child have a misshaped skull/head? Yes No

Did you breast feed your child? Yes No
Does your child prefer one breast over the other? Yes No
If yes, which side? Right Left
Does your child have any food allergies? Yes No
If yes, please list: _____________________________________________________________
Has your child been immunized? Yes No

Has your child had any surgeries? Yes No
If yes, explain. ______________________________________________________________
Has your child been on antibiotics? Yes No
If yes, how often and what for? _______________________________________________
Is your child currently taking any medication/vitamins? Yes No
If yes, please list: ____________________________________________________________

**Baby/Toddler (0-4 years of age):**

Have any of the following occurred?

| | | |
|---|---|---|
| Fall from a changing table | Frequent crying spells | Tumble down stairs |
| Fall of playground equipment | Fall out of crib | Frequent ear infections |
| Tonsillitis | Frequent fevers | Frequent diarrhea |
| Constipation | Sleeping problems | Colic |
| Repeated infections/colds | Reaction to vaccines | (+ or -) weight gain |

Other (Please explain): ____________________________________________________________
If yes to above, explain: ___________________________________________________________

**Child (5-12 years of age):**

Have any of the following occurred?

| | | | |
|---|---|---|---|
| Fall from a tree | Fall off of a bicycle | Sports accident | Car accident |
| Fall on playground | Stomach pains | Bed wetting | Scoliosis |
| Hyperactivity/ADHD | Learning difficulties | Asthma | Allergies |
| Leg/Knee Pains | Headaches | | |

Other (Please explain): ____________________________________________________________
If yes to above, explain: ___________________________________________________________

Which of the above bothers your child the most? _____________________________________
When did it begin? _________________________________________________________________
Is it getting worse? Yes No
Is the pain: Constant Intermittent Sporadic
Affect on activity? Not at all Somewhat Always

Does your child participate in any of the following?

| | | | |
|---|---|---|---|
| Soccer | Football | Gymnastics | Karate |
| Hockey | Lacrosse | Basketball | Dance |
| Wrestling | Baseball/Softball | Volleyball | Tennis |
| Swimming | Other ______________________________ | | |

How is your child's diet? Well balanced Average High sugar/processed foods
Number of hours your child sleeps? ___________/hours per day
Sleep Quality? Good Fair Poor

**Informed Consent to Chiropractic Treatment**

The nature of chiropractic treatment: The doctor will use his/her hands or a mechanical device in order to move your joints. You may feel a “click” or “pop”, such as the noise when a knuckle is “cracked”, and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric stimulation, therapeutic ultrasound and exercise, etc. may also be used.

Possible Risks: As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligament sprain, dislocations of joints, or injury to intervertebral discs, nerves or the spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or minor complications.

Probability of risks occurring: The risks of complications due to chiropractic treatment have been described as “rare”. The risk of cerebrovascular injury or stroke, has been estimated at on in one million to one in twenty million, and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered “rare”.

Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

Unusual risks: I have had the following unusual risks of my case explained to me.

I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment and herby give my full consent to treatment.

PATIENT: ______________________________ ______________________________ ______________
Printed Name Signature Date

GUARDIAN: ___________________________ ______________________________ ________________
Printed Name Signature Relationship to Patient

# HIPAA Policy

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to 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. You may request to view charges to your records. 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 to 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 such as quality assessments and physician's certi cates. 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.*

Print Patient Name:_______________________________________ Date: ________________
Signature of Patient/Guardian:______________________________________________
Relationship to Patient (if applicable): ________________________________________

**Financial Policy**

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

- We urge our patients to follow the doctors' recommendations for care to see the intended results. Please keep your appointments as scheduled or call our office within 24 hours to make any changes.
- I authorize Balance Restored Chiropractic to release any information deemed appropriate concerning my physical condition to any insurance company, attorney, or adjuster in order to process any claim for reimbursement charges incurred by me.
- In order to file your claims in a timely manner, we need current, accurate insurance information for you and your dependents. We will do our best to confirm your eligibility and level of insurance coverage for care; however, it is ultimately your responsibility to know your own insurance benefits in relation to what your insurance covers and what it doesn't. Should your insurance carrier determine that your any or all of our services are ineligible for payment, you will be billed for those services.
- If you have any questions about our financial policies, please ask our staff. 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 pay 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 any chiropractic care deemed maintenance or wellness care by your carrier (as well as other items that may arise in the future). 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. If you have other questions, please ask our staff. Signing below means that you have received and understand this notice.*

Signature: ____________________________________________ Date: _______________

Relationship to Patient (if applicable): ________________________________________