PEDIATRIC INTAKE FORM

Date:_____

PERSONAL INFORMATION

Child's First Name: _____ M.I.: _____ Last Name: _____

Preferred Name: _____ SSN: _____

Address: _____

City/State/Zip: _____

Birth Date: _____ Age: _____ Sex: M F

# of Siblings: _____ Sibling(s) Names and Ages: _____

Parents' Names: _____

Best Contact Phone: ( ) _____ Alternate Phone: ( ) _____

Email: _____ Do you have health insurance? Y N Carrier? _____

Who is responsible for the account? _____Who can we thank for referring you? _____

REASON FOR SEEKING CARE

What is your reason for seeking care at the Pecatonica Chiropractic Center?

_____

_____

When did this begin? _____

Are there any major injuries and/or surgeries we should know about?

_____

What is this affecting that is MOST important in your child's life? (List all that apply)

_____

Has your child seen any other providers for this condition? (List all that apply)

_____

Has your child seen a chiropractor before? Y N

How long ago? _____ Clinic/Doctor Name: _____

What is your level of commitment to your child's health? 1 2 3 4 5 6 7 8 9 10

Explain: _____

What health goal, if your child were to complete or accomplish it, would have the greatest impact on his/her life?

_____

HEALTH CONCERNS

- ☐ Anxiety/Depression
- ☐ Constipation/Diarrhea
- ☐ Nausea/Vomiting
- ☐ Diabetes
- ☐ Bed Wetting
- ☐ Overweight
- ☐ Frequent Sickness
- ☐ ADD/ADHD
- ☐ Detachment/Distant
- ☐ Irritability/Nervous
- ☐ Other _____
- ☐ Other _____

Explain any boxes checked above:

_____

_____

_____

Is there anything else regarding your child's current condition you feel the doctor should know?

_____

_____

_____

MEDICATIONS

- ☐ Anxiety/Depression
- ☐ Asthma
- ☐ Pain Narcotics
- ☐ Antibiotics
- ☐ Migrain/Headache
- ☐ Acid Reflux
- ☐ ADD/ADHD
- ☐ Digestive
- ☐ Other _____
- ☐ Other _____
- ☐ Other _____

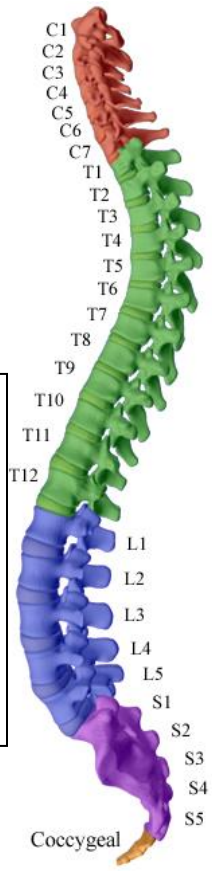
- ☐ Fatigue/Sleep Issues
- ☐ Asthma/Chronic Bronchitis
- ☐ Colic/Acid Reflux
- ☐ Back/Neck Pain/Stiffness
- ☐ Difficulty Gaining Weight
- ☐ Ear or Other Infections
- ☐ Headaches
- ☐ Learning Disorders
- ☐ Sinus Troubles/Allergies
- ☐ Autism/Asperger's

DID YOU KNOW....

Each health concern relates to a specific area of the spine and nervous system? Please circle below:

Sore Throat
Stiff Neck
Radiating Arm Pain
Hand/Finger Numbness
Asthma
Allergies
High Blood Pressure
Heart Conditions

Constipation
Colitis
Diarrhea
Gas Pain
Irritable Bowel
Bladder Problems
Menstrual Problems
Low Back Pain
Pain or Numbness in Legs
Reproductive Problems



Headaches
Migraines
Dizziness
Sinus Problems
Allergies
Fatigue/Sleep problems
Head Colds
Vision Problems
Difficulty Concentrating
Hearing Problems

Middle Back Pain
Congestion
Difficulty Breathing
Bronchitis
Pneumonia
Gallbladder Conditions
Stomach Problems
Ulcers
Gastritis
Kidney Problems
Indigestion

VITAMINS / SUPPLEMENTS

- ☐ Multivitamin
- ☐ Vitamin D3
- ☐ Fish Oil/Omega – 3
- ☐ Probiotics
- ☐ Other _____
- ☐ Other _____

Explain any boxes checked above:

_____

_____

PRENATAL HISTORY

Location of Birth : Home Birthing Center Hospital Other: _____

Did any of the following happen during delivery:

C-Section delivery Doctor pulled or twisted baby Anesthesia Labor was induced

Forceps/Vacuum extraction Premature Delivery Special medical procedures/tests

Describe any of the above plus any additional complications experienced during labor :

_____

_____

During pregnancy, did you use any drugs, tobacco, alcohol, and/or medications? If yes, please list:

_____

Did you experience any illness while pregnant? Y N If yes, explain: _____

Do you have any physical disabilities? Y N If yes, explain: _____

Birth Weight: _____ Birth Length: _____ APGAR Scores: _____

Ultrasound used during pregnancy? Y N Number of times: _____

Did you breastfeed the baby? Y N If yes, how long: _____

Did you formula-feed the baby? Y N If yes, how long: _____

At what age did you introduce: Solids: _____ Cow's Milk: _____

LIFESTYLE HABITS

Does your child exercise daily? Y N How much? _____

Does your child drink soda? Y N How much/often? _____

Does your child have a positive self-esteem or self-image? Y N

Does your child watch more than an hour of TV per day? Y N How much? _____

Does your child eat balanced meals? Y N

Does your child experience prolonged sadness? Y N

Explain: _____

Does your child have difficulty sleeping? Y N Explain: _____

Does your child play video games? Y N How much/often? _____

CURRENT HEALTH STATUS

The National Safety Council reports approximately 50% of children fall head first from a high place during their first year of life (bed, changing table, stairs, etc.). Was this the case for your child? Y N

Explain: _____

Has your child ever been hospitalized or had surgery? Y N Explain: _____

Does your child have difficulty interacting with others? Y N Explain: _____

Have you noticed that your child is nervous, twitches, shakes, or exhibits rocking behavior? Y N

Explain: _____

Has your child been involved in any high impact/contact sports (soccer, football, basketball, volleyball, cheerleading, etc.)? Y N
Please List: _____

Are you aware of any food allergies or intolerance? Y N Explain: _____

Has your child received all recommended vaccinations? Y N Explain: _____

Please rate stress levels on a scale of 1-10 (10 being highest)

School: 1 2 3 4 5 6 7 8 9 10 Personal: 1 2 3 4 5 6 7 8 9 10

INSURANCE AGREEMENT

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Pecatonica Chiropractic Center will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Pecatonica Chiropractic Center will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I further understand that any unpaid balance of 60 days or more will be charged 1.5% interest on the unpaid balance each month. In the event that I fail to pay the amounts when due, I understand that I will be in default of our agreement.

DELINQUENCY AND DEFAULT; I AGREE TO PAY THE COSTS INCURRED TO COLLECT THIS BILL IN THE EVENT OF MY DEFAULT IN PAYMENT, INCLUDING YOUR REASONABLE ATTORNEY'S FEES.

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL MEDICAL RECORDS AND/OR INFORMATION

I authorize Pecatonica Chiropractic Center to release any medical information or X-rays as needed to process claims for services rendered.

I understand that this release is revocable at any time prior to the release of this information.

Assignment of Payment

My attorney and/or insurance company are hereby requested and authorized to pay direct to Pecatonica Chiropractic Center any monies due on the account, the same to be deducted from any settlement made on our behalf.

Further, I agree to pay Pecatonica Chiropractic Center the difference, if any between the total amount of charges and the amount paid by the attorney and/or insurance company. It is further understood that I, the undersigned, agree to pay Pecatonica Chiropractic Center the full amount of charges, should my condition e such that it is not covered by my policy or **if for any reason** the insurance company refuses to pay my claim.

Dated at 427 Main Street, Pecatonica, IL 61063 this _____day of_____, 20_____

Witness:

_____ _____

Signature of Patient

PATIENT CONSENT FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

_____, hereby states that by signing this Consent, I acknowledge and agree as follows:

1. The Practice's Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out its health care operations. The Practice explained to me that the Privacy Notice will be available to me in the future at my request. The Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.
2. The Practice reserves the right to change its privacy practices that are described in its privacy Notice, in accordance with applicable law.
3. I understand that, and consent to, the following appointment reminders that will be used by the Practice: a) a postcard mailed to me at the address provided by me; and b) telephoning my home and leaving a message on my answering machine or with the individual answering the phone.
4. The Practice may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the Practice to treat me and obtain payment for that treatment, and as necessary for the Practice to conduct its specific health care operations.
5. I understand that I have a right to request that the Practice restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, the Practice is not required to agree to any restrictions that I have requested. If the Practice agrees to a requested restriction, then the restriction is binding on the Practice.
6. I understand that this Consent is valid for seven years. I further understand that I have the right to revoke this Consent, in writing, at any time for all *future* transactions, with the understanding that any such revocation shall not apply to the extent that the Practice has already taken action in reliance on this consent.
7. I understand that if I revoke this consent at any time, the Practice has the right to refuse to treat me.
8. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then the Practice will not treat me.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

_____ _____

Name of Individual (Printed) Signature of Individual

_____ _____

Signature of Legal Representative Relationship

(e.g., Attorney-In-Fact, Guardian, Parent if a minor):

Date Signed _____/_____/_____ Witness:_____