PEDIATRIC INTAKE FORM

PERSONAL INFORMATION

Child's First Name: _____ M.I.: _____ Last Name: _____
Preferred Name: _____ Social Security Number:_____
Address: _____
City / State / Zip: _____
Birth Date: _____ Age: _____ Sex: M F
Parents' Names:_____
Best Contact Phone: ( ) _____ Email: _____
Who can we thank for referring you or how did you hear about Redmond Roots Chiropractic?
_____

REASON FOR SEEKING CARE

What is your reason for seeking care at Redmond Roots Chiropractic?
_____
When did this begin? (If applicable) _____
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? Yes No
How long ago? _____ Clinic/Doctor Name: _____
What is your reason for the change? (If applicable) _____
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 ☐Fatigue/Sleep Issues ☐Digestive Troubles ☐Nausea/Vomiting ☐Loss of Concentration
☐Headaches ☐Neck/Back Pain ☐Stiffness/Flexibility ☐Pain in Arms/Legs ☐Sinus Troubles/Allergies ☐Bed Wetting
☐Overweight ☐ADD/ADHD ☐Detachment/Distant ☐Asthma/Chronic Bronchitis ☐Colic/Acid Reflux ☐Diabetes
☐Ear or Other Infections ☐Learning Disorders ☐Autism/Asperger's ☐Irritabilty/Nervous ☐Frequent Sickness
☐Other _____☐Other _____

Explain any boxes checked above or add additional concerns: _____

_____

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

MEDICATIONS

☐Anxiety/Depression ☐Migraine/Headache ☐Asthma ☐Acid Reflux ☐Pain Narcotics ☐ADD/ADHD ☐Antibiotics
☐Digestive ☐Others _____

Explain any checked boxes above:_____

_____

SUPPLEMENTS/VITAMINS

☐Multi-Vitamin ☐Fish Oil/Omega-3 ☐Vitamin D3 ☐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 delivery:
_____

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

Did you experience any illness while pregnant? Yes No If yes, explain: _____

Birth weight: _____ Birth length: _____ APGAR scores (if remembered): _____

Ultrasound used during pregnancy? Yes No Number of times: _____

Did you breastfeed the baby? Yes No If yes, how long: _____

Did you formula-feed the baby? Yes No If yes, how long: _____

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

LIFESTYLE HABITS

Does your child exercise daily? Yes No How much?_____

Does your child drink soda? Yes No How much/often? _____

Does your child have a positive self-esteem or self-image? Yes No

Does your child watch more than an hour of TV per day? Yes No How much?_____

Does your child eat balanced meals? Yes No

Does your child have difficulty sleeping? Yes No Explain: _____

Does your child play video games? Yes No How much? _____

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? Yes No
Explain: _____

Has your child ever been hospitalized or had surgery? Yes No
Explain:_____

Does your child have difficulty interacting with others? Yes No
Explain:_____

Have you noticed that your child is nervous, twitches, shakes, or exhibits rocking behavior? Yes No
Explain: _____

Has your child been involved in any high impact/contact sports (soccer, football, martial arts, cheerleading, etc.)?
Yes No Please list: _____

Are you aware of any food allergies or intolerance? Yes No Explain: _____

Has your child received all recommended vaccinations? Yes No 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

PERMISSION TO TREAT A MINOR

I, (Parent/Guardian) _____, give Redmond Roots Chiropractic permission to examine, x-ray (if necessary), and treat _____(name of minor).

Signature: _____ Date: _____

PATIENT HIPAA CONSENT FORM

Protecting the privacy of your personal health information is important to us. Disclosure of your 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. 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 certificates. 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: _____

Signature:_____ Relationship to Patient: _____

FINANCIAL POLICY

Our goal is to provide the highest quality of 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.

• I authorize Redmond Roots 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 of charges incurred by me.

• I authorize the direct payment to Redmond Roots Chiropractic of any sum I now or hereafter owe by my attorney out of settlement of my case, and by any insurance company obligated to make payment to me or Redmond Roots Chiropractic based in whole or in part upon the charges made for services received. I hereby appoint Redmond Roots Chiropractic authority to endorse and cash checks, drafts, or money orders made payable to the undersigned or as co-payee with this clinic for payments due for services rendered on behalf of the undersigned by Redmond Roots Chiropractic.

• 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 any or all of our services are ineligible for payment, you will be billed directly for those services.

• 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 your initial visit and 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. This notice gives our opinion, not an official Medicare or other insurance carrier's decision. If you have other questions, please ask our front desk. Signing below means that you have received and understand this notice.

Date: _____ Signature: _____

AUTHORIZATION FOR CARE

I hereby authorize doctors and staff at Redmond Roots Chiropractic to treat my condition as deemed appropriate. At Redmond Roots 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 my doctor or any staff member of Redmond Roots Chiropractic responsible for any errors or omissions that I may have made in the completion of this form. 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: _____ Signature: _____