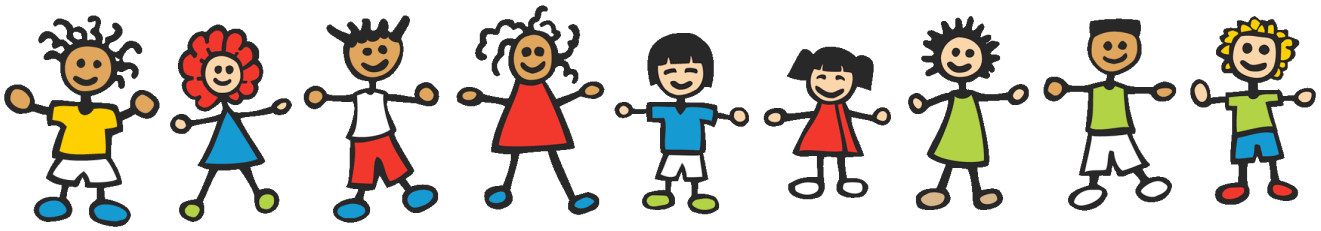
Pediatric Intake Form

BROOKS FAMILY CHIROPRACTIC



Patient Information

Child's Name:_____ Today's Date:_____

Birthdate:_____ Age:_____ Sex: ☐ Male ☐ Female

Parent's/Guardian's Names:_____

Home Address:_____

City:_____ State:_____ Zip:_____

Parent's Home Phone:_____

Parent's Cell Phone:_____

Parent's Email:_____

Siblings and ages:_____

How did you hear about us?_____

Previous Chiropractic Care? ☐ No ☐ Yes:_____

Family Doctor or other Health Care Professional

Name:_____Professional Designation:_____

Clinic Name:_____

Date and reason of last visit:_____

May we communicate with your family doctor regarding your child's care if necessary? ☐ No ☐ Yes

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Why have you decided to have your child evaluated by a Chiropractor?

☐ I recently had my spine and nervous system checked and understand the value in getting my child checked.
☐ I have concerns about my child's health and I am looking for answers.
☐ My child has a specific condition and I have learned that chiropractic may be able to help.
☐ I want to improve my child's immune system.
☐ Other:_____

Why This Form Is Important

The human body is designed to be healthy. The primary system in the body which coordinates health and function is the nervous system. Your nervous system is surrounded and protected by the bones of the spine called **vertebrae**. Many of the common health challenges that adults experience have their origins during the **developmental years**, some starting at birth. Layers of damage to the spine and nervous system occur as a result of various **traumas, toxins, and environmental stress**. The result may be misalignment to the spinal column and damage to the nervous system in a condition called **vertebral subluxation**. Please answer the following questions to give us a better understanding about your child's state of wellness and factors which may be contributing to vertebral subluxation and impeding you child's **ability to heal**.

What signals has your child's body been communicating? (Please circle all that apply)

Asthma	Frequent diarrhea	Failure to thrive/slow weight gain
Respiratory tract infections	Constipation	Slow or absent reflexes
Sinus problems	Flatulence	Asymmetrical crawling or gait
Ear infections	Headaches/migraines	Weight challenges
Tonsillitis	Neck pain	Bed wetting
Strep throat	Torticolis/head tilt	Sleep problems
Frequent colds/croup/cough	Back pain	Night terrors
Recurrent Fevers	Growing pains	Tip toe walking
Eczema	Scoliosis	Regression of milestones
Rashes	Red/swollen/painful joints	Seizures
Allergies	Colic as an infant	Tremors/shaking
Food sensitivities	Depression	ADD/ADHD
Digestive problems	Anxiety	Autism/PPD

Do you have a specific concern that brings you in?

☐ No, I am interested in having my child's nervous system assessed to achieve optimal health and functioning.
*If no, please skip to **Pre-natal Profile**.*

☐ Yes:_____

If yes, please answer the following questions:

Does your child appear to be in pain or discomfort? ☐ No ☐ Yes

How long has your child been experiencing this?_____

Is it getting better, worse or staying the same?_____

Was the onset sudden or gradual?_____

Have you seen other health professionals regarding this complaint?_____

What treatment did they use?_____

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Has your child taken any medication for this complaint? ☐ No ☐ Yes:_____

Has your child ever experienced this complaint before? ☐ No ☐ Yes:_____

Did they receive any treatment at that time? ☐ No ☐ Yes

Has your child had x-rays/CT/MRI/PET/US in relation to the current complaint? ☐ No ☐ Yes

Pre-natal Profile

☐ Adopted ☐ Prenatal history unknown ☐ Birth history unknown

Complications during pregnancy? ☐ No ☐ Yes:_____

Ultrasounds during pregnancy? ☐ No ☐ Yes and how many:_____

Medications during pregnancy (include OTC)? ☐ No ☐ Yes:_____

Exposure to alcohol/cigarettes/second hand smoke during pregnancy? ☐ No ☐ Yes:_____

Birth & Infant History

Location of birth: ☐ Home ☐ Hospital ☐ Birth Center ☐ Other:_____

How many weeks gestation was your child at birth?_____

Medications during labor/delivery? ☐ No ☐ Yes:_____

Was anything used to induce labor? ☐ No ☐ Yes:_____

How did you deliver your child? ☐ Vaginal ☐ Cesarean ☐ Breech ☐ OP

Were any of the following interventions used? ☐ Forceps ☐ Vacuum Extraction ☐ Other:_____

Were there any complications during delivery? ☐ No ☐ Yes:_____

Did your child receive any medications at birth? ☐ No ☐ Yes:_____

Any concerns about misshapen head at birth? ☐ No ☐ Yes

Was your child breast-fed, and for how long? ☐ No ☐ Yes:_____

Was your child formula-fed, and for how long? ☐ No ☐ Yes:_____

Did your child show any sensitivities to breast milk or formula? ☐ No ☐ Yes:_____

Did you introduce cereal/grains to your child within the first year? ☐ No ☐ Yes:_____

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Physical Traumas

Has your child fallen from any high places: ☐ No ☐ Yes:_____

Has your child ever been in a car accident? ☐ No ☐ Yes:_____

Has your child been to the ER? ☐ No ☐ Yes:_____

Has your child broken any bones? ☐ No ☐ Yes:_____

Has your child had any surgeries? ☐ No ☐ Yes:_____

Does your child spend time on electronic devices? ☐ Never ☐ Rarely ☐ Daily ☐ Several hours/day

Does your child watch TV? ☐ Never ☐ Rarely ☐ Daily ☐ Several hours/day

Does your child exercise? ☐ No ☐ Daily ☐ Weekly ☐ Seasonally

Does your child play contact sports? ☐ No ☐ Yes:_____

Does your child show excessive/uneven shoe wearing out? ☐ No ☐ Yes

Does your child wear orthotics? ☐ No ☐ Yes: How long have they worn them?_____

Chemical Stressors

Have you chosen to vaccinate your child? ☐ No ☐ Yes: On schedule ☐ Yes: On a delayed schedule

Reason for vaccination? ☐ Informed decision ☐ Didn't know I had a choice ☐ It was recommended

Any reactions to vaccination? ☐ Fever ☐ Seizures ☐ Rash ☐ Diarrhea ☐ Fatigue
☐ Prolonged Crying ☐ Developmental regression ☐ Welt at injection site

Has your child been exposed to antibiotics? ☐ No ☐ Yes:_____

Were probiotics used at the same time as antibiotics? ☐ No ☐ Yes

Does your child take any medications? (include OTC) ☐ No ☐ Yes:_____

Does your child take any supplements or homeopathics? ☐ No ☐ Yes:_____

How many glasses of water does your child drink/day? ☐ 0 ☐ 1-3 ☐ 4-6 ☐ 7-9 ☐ 10+

How many glasses of juice/soda/sports drinks does your child drink/day? ☐ 0 ☐ 1-3 ☐ 4-6 ☐ 7-9 ☐ 10+

Does your child follow any dietary restrictions? ☐ No ☐ Yes:_____

Does your child have any food/milk sensitivities? ☐ No ☐ Yes:_____

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Goals & Consent

Do you think your child is developmentally appropriate for their age:

Intellectually: ☐ Yes ☐ No:_____

Emotionally: ☐ Yes ☐ No:_____

Physically: ☐ Yes ☐ No:_____

What is your primary goal for your child at our clinic?_____

Our goals are to provide a detailed assessment of your child's current health status and provide to you the resources for a highly engaged and healthy child whose body is functioning at its absolute peak potential while they grow. Essential to this healthy growth is a nervous system functioning free from interference called subluxations. You have taken an important step for you child's future with chiropractic care!

Consent to Evaluation and Treatment of a Minor Child

I_____, being the parent/legal guardian of
(Parent/legal guardian)

_____, hereby grant permission for my child to
(Minor child/patient)

receive a chiropractic evaluation including history, spinal scan, examination, orthopedic/reflex tests, and chiropractic treatment. Any findings will be communicated before consulting to commencement of treatment, if appropriate.

_____ _____
Consenting Guardian's Signature Date

USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION
ACKNOWLEDGEMENT AND CONSENT

The federal laws that protect your protected health information ("HIPAA") do not provide you with complete privacy. HIPAA allows your health care provider to use or disclose your protected health care information without further authorization or consent from you in a number of circumstances, such as:

- In the course of providing you treatment;
- In the event a referral to another health care provider if/as necessary for the diagnosis, assessment, or treatment of your health condition;
- For insurance and billing purposes;
- For internal clinic purposes (related to quality control or operations); and
- In limited and unusual circumstances related to public health matters and research.

Our privacy policy. We are very concerned with protecting your privacy, and always will respect the privacy of your health information. Along with this consent form, you will be given a copy of our privacy policy, in detail. You have the right to review our privacy policy before you sign this consent form. We reserve the right to change our privacy policy. If we make a change, we will notify you in writing when you come in for treatment or by mail.

Your right to limit uses or disclosures. You have the right to restrict our ability to use or disclose your protected health information with specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, you must inform us in writing.

Your right to authorize us to disclose your protected health information. You have the right to authorize us to disclose your protected health information to specific individuals, companies, or organizations. If you would like to make an authorization, we will ask you to complete an authorization form.

Your right to revoke any limitation, authorization, or consent. You have the right to revoke any limitation or authorization to use or disclose your protected health information at any time. Your revocation must be in writing. If you refuse to give us an authorization or consent or revoke any authorization or consent in the future, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

I ACKNOWLEDGE receipt of the PRIVACY POLICY and CONSENT to my personal health information being used in the manner described above. I am also acknowledging that I have received a copy of this consent.

Patient Name Printed	Date
Patient (or Personal Representative) Signature	Authorized Provider Representative
Personal Representative's Name Printed	Personal Representative's Authority

I am acknowledging that I have received a copy of the PRIVACY POLICY and this consent but DECLINE to give my chiropractor and members of the practice staff consent to use my protected health information for any purpose other than treatment and those required by federal law.

Patient Name Printed	Date
Patient (or Personal Representative) Signature	Personal Representative's Authority

BROOKS FAMILY CHIROPRACTIC

Our Financial Policy

Brooks Family Chiropractic, S.C. is happy to accept your cash, check, or credit card. We also accept Health Savings Accounts and Flex Spending Accounts.

Brooks Family Chiropractic, S.C. is not in-network with any insurance companies with the exception of Medicaid/ Forward Health and Medicare.
As a courtesy, we will provide you with an itemized bill to submit to your insurance company.

Late Fees
Any outstanding balance over 30 days is subject to a 10% monthly late fee.

Please CIRLCE your preferred method of payment:

1) Medicaid/Forward Health Insurance:
A copy of your insurance card is required at time of service. If you have a copay, it must be paid at the time of service. If you miss more than one appointment without 24 hour notice you will be dismissed from our services indefinitely.

2) Medicare Insurance:
Medicare will not cover your initial exam. We require that you pay for your initial exam at the time of service. Your subsequent visits will be billed to Medicare.
A copy of your insurance card is required at the time of service.

3) Time-of-Service Rates:
A discount will be given for payment at the time of service.
Initial Exam/Consultation/Thermography: $60.00
Chiropractic visit/adjustment, 3-4 spinal regions: $37.00
Chiropractic visit/adjustment, extraspinal/extremity: $20.00
Myofascial release: Included

4) Children age 19 and under:
Initial Exam/Consultation/Thermography: $60.00
Chiropractic visit/adjustment, 3-4 spinal regions: $20.00/child

4) Pre-Paid Plan:
You have the option to pre-pay for 6 visits and we will decrease our rate from $37.00 for each adjustment to $34.00 for each adjustment. This will save you $18.00 per 6 adjustments.

We require a 24 hour notice if you need to change your scheduled appointment.
**A $30.00 service fee will be charged if you miss an appointment without 24 hour notice.*

I have been given this financial policy and clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment.

_____ _____
Signature of Patient Date