SCHOOL AGE NEW PATIENT INTAKE FORM

sweet FAMILY CHIROPRACTIC

Personal Information

Child's Name: _____Today's Date: _____

Date of Birth (Month/Day/Year): _____ Gender: *Male* *Female*

Address of Child: _____

City: _____State: _____ Zip: _____

Mother's Name: _____

Father's Name: _____

Names and Ages of Siblings: _____

_____

_____

WHOM MAY WE THANK FOR REFERRING YOU?

PRIMARY Contact Name: _____

Relationship to child: _____

Home Phone: (_____) _____ Work Phone: (_____) _____

Cell Phone: (_____) _____ Email: _____

Leave messages on (circle one): *Home* *Work* *Cell* *Don't leave messages*

AN ADDITIONAL EMERGENCY CONTACT NAME (Optional): _____

RELATIONSHIP TO CHILD: _____ **PHONE NUMBER: (_____)** _____

Primary Care Physician/Pediatrician Name: _____

City: _____ State: _____ Phone Number: (_____) _____

Date of Last Visit? _____ Reason for Visit? _____

_____

_____

Insurance Information

Insurance Carrier: _____

Policy Number: _____ Group Number: _____

Name of Insured: _____

Date of Birth of Insured (Month/Day/Year): _____

SSN of Insured: _____-_____-_____ Relationship to Patient: _____

Address of Insured: _____

City: _____ State: _____ Zip: _____

What is the best phone number to reach Insured: (_____) _____-_____

Is this (please circle one): *home phone* *cell phone* *work phone* *other:* _____

Marital Status of Insured: *Single* *Married* *Other:* _____

Employment Status of Insured: *Full-time* *Part-time* *Seasonal* *Self-employed* *Unemployed* *Retired*

Employer: _____Occupation: _____

Family Health Problems

Describe any health problems that:

Exist on Mother's side of family: _____

_____

Exist on Father's side of family: _____

_____

Affect any siblings (including scoliosis): _____

_____

Stressors

1. Chemical Stressors

At any time, has the child:

- Received any vaccinations? *Yes* *No* If yes, which ones?_____

  _____
- Had any reaction to vaccinations? *Yes* *No* If yes, please describe: _____

  _____
- Received doses of antibiotics in the last 6 months? *Yes* *No* How many? ____

Please list child's current medications: _____

_____

Does the child live with pets? *Yes* *No* What type? _____

Does the child live with smokers? *Yes* *No* Who & how much? _____

2. Psychological Stressors

Does the child have any diagnosed behavior problems? *Yes* *No*

- If so, please list: _____

Does the child go to daycare? *Yes* *No* Beginning at what age? _____

Average number of hours child spends on TV/Computer/Electronics per week? _____

3. Traumatic Stressors

Any major falls since birth? *Yes* *No* Describe?_____

- Did fall result in: *Stitches* *Fracture* *Break* *Other:* _____

Has the child been in any car accidents? *Yes* *No*

- Briefly describe: _____
- List anyone who was injured: _____

Has the child had any hospitalizations/surgeries? *Yes* *No*

- Please explain: _____

4. Physical Stressors

Does the child play organized sports? *Yes* *No* Hours per week? _____

- Age child began? _____
- Describe sports/activities: _____

Weight of school back pack? _____

Primary Health Concern

As a family chiropractic office, we focus on your child's ability to be healthy. Our goals are first to address the issues that brought you to this office, and second, to offer you and your child the opportunity of improved health and potential wellness services.

IF YOUR CHILD HAS NO SYMPTOMS OR COMPLAINTS AND IS HERE FOR WELLNESS SERVICES, PLEASE PLACE AN X IN THE BOX. OTHERS, COMPLETE THE FOLLOWING ☐

Briefly describe the primary symptoms/area of complaint that prompted you to seek care for your child today: _____

_____

When did this begin?_____

What pain is the child experiencing? *Achy* *Dull* *Sharp* *Burning* *Numb* *Stabbing* *Varying* *Travels* *Constant* *Other (explain):* _____

Since the problem started, is it: *About the same* *Getting better* *Getting worse*

What makes this better? _____

worse? _____

Explain how this condition interferes with:

School: _____

Recreational activities, sports: _____

Household responsibilities: _____

Personal relationships: _____

Sleep: _____

Name(s) of other doctor(s) seen for this problem and phone number(s): _____

_____

_____

CONSENT FOR USE OR DISCLOSURE OF HEALTH INFORMATION

OUR PRIVACY PLEDGE

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have and always will respect the privacy of your health information. We may have to use or disclose your healthcare or billing information when:

1. It is necessary to refer you to another healthcare provider or hospital for the diagnosis, assessment, or treatment of your health condition.
2. Another party, such as a health insurance company, is responsible for payment of your services.
3. We need the information within our practice for quality control or other operational purposes.

Along with this consent form you will be given, at your request, a copy of our privacy notice that describes our privacy policy in detail. You have the right to review the notice before you sign this consent form. We reserve the right to change our privacy practices as described in this notice. If we make changes, we will notify you in writing.

Your chiropractor and members of the staff may need to use your name, address, phone number, and clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If this contact is made by phone and you are not available, a message will be left on your answering machine or with the person answering the phone. By signing this form, you are giving us authorization to contact you with these reminders and information and to leave messages as described above.

We do not give or sell patient information to any outside marketing organizations. All marketing services are by those staff members in our practice.

YOU HAVE THE RIGHT TO LIMIT USES OF DISCLOSURES

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. Although we are not required to agree to your restrictions, if we choose to do so, the restrictions are binding on us.

YOU HAVE THE RIGHT TO REVOKE AUTHORIZATION

You may revoke any authorization at any time, however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released health information prior to receiving your request. If you are required to give authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if we decide to contest any of your claims.

I have read the consent policy and agree to its terms. I also acknowledge that I have been offered and/or received a copy of this consent form and a copy of the privacy notice (Notice of Privacy Practices for Protected Health Information).

PRINT NAME OF PATIENT/LEGAL REPRESENTATIVE	**DATE**
SIGNATURE OF PATIENT/LEGAL REPRESENTATIVE	**RELATIONSHIP TO PATIENT**

INFORMED CONSENT TO CHIROPRACTIC TREATMENT OF CARE

PATIENT NAME: _____

I, hereby, request and consent to the performance of procedures which are within the scope of practice of chiropractic, including but not limited to, chiropractic adjustments, various modes of physical therapy, and diagnostic X-rays, on me (or the patient named above, for whom I am legally responsible) by Dr. Heather Sweet and/or any other licensed doctor or chiropractor who will now or in the future treat me while being employed by, working or associated with, or serving as back-up for Dr. Heather Sweet at Sweet Family Chiropractic.

I have had the opportunity to discuss with Dr. Heather Sweet and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand the results are not guaranteed.

I understand and am informed that there are some risks to chiropractic treatment, including but not limited to, fractures, disc injuries, strokes, dislocations, and sprains/strains. I do not expect the doctor to anticipate and explain all the risks and complications. I wish to rely on the doctor to exercise judgement during the procedure which the doctor deems is in my best interest at the time and is based on the facts known.

I have read or have had read to me the above consent. I have also had an opportunity to ask questions about the content, and by signing below I agree to the above-named procedures. I intend for this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

_____ _____

PRINT NAME OF PATIENT/LEGAL REPRESENTATIVE **DATE**

_____ _____

SIGNATURE OF PATIENT/LEGAL REPRESENTATIVE **RELATIONSHIP TO PATIENT**