

Pediatric Intake Form

6 to 12 years old

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Child's Legal Name:							
Address:							
Home Phone: Parent's Cell Phone:							
Date of Birth:/ Age: Gender: M F Social Security #:							
Mother's Name: Father's Name:							
Sibling's Name(s) and ages:		-					
How did you hear about our office?							
Please select any of the applicable reasons that you are pursuing chiropractic care for your child:							
He/she is continuing care from another chiro	•						
I'm concerned about his/her health and am lo	.	ild for subluxations.					
He/She has a specific condition that concerns	•						
I have been told that chiropractic care will benefit my child, however, I am not sure how it will help.							
Is this visit the result of an auto injury?	If yes, when was it?						
Do you have family members with similar health concerns? If yes, who?							
Has your child seen another doctor for the issue he/she is being seen today?							
If yes, please provide name of doctor:							
INSURANCE INFORMATION							
Insurance company:							
Policy #:Policy Holder:							
AUTHORIZATION AND RELEASE: I authorize payment of insu							
agree to allow this chiropractic office to use the ir Protected Health Information (PHI) for the purpose of treatment, payment, healthcare operations and coordination of care. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate myschedule of care as determined by my treating doctor, any fees for professional services will be immediately due							
and payable. I understand that interest is charged on over this chiropractic office to use their Protected Health Informa	lue accounts at the annual ra	ate of 16%. The patient understands and agrees to allow					
of care. We want you to know how your Protected Health It you would like to have a more detailed account of our poli	nformation is going to be used cies and procedures concern:	d in this office and your nights concerning those records. If ning the privacy of your Protected Health Information we					
encourage you to read the HIPAA NO TICE that is available permission to receive my personal health information:	to you at the front desk before	re signing this consent. The following person(s) have my					
Pa tie nt's Sig na ture		 Da te					
Guardian's Signature Authorizing Care							

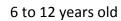




6 to 12 years old

PRENATAL HISTORY Was the patient adopted? Were there complications during the pregnancy? If yes, explain:
Were ultrasounds performed during pregnancy? If yes, how many?
Were medications/drugs/caffeine taken during pregnancy? If yes, please list type and amount:
Were cigarettes or alcohol used during pregnancy? If yes, please list type and amount:
Location of birth: in hospital in birthing center at home
Birth Intervention:
mother induced mother medicated (Pitocin, etc.) forceps vacuum extracted
Were there complications during delivery? If yes, please explain:
Are there genetic disorders/disabilities? If yes, please explain:
HEALTH HISTORY
Does child have any known allergies? If yes, to what?
Has your child ever taken antibiotics? If yes, what kind and when?
List any current medications:
List any past medications:
Has child ever had any surgeries? If yes, what surgery and when?
Has child been diagnosed with cancer or any other illness? If yes, please explain:

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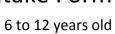




The following questions are designed to help the doctor provide the best possible care for your child.					
Reason for today's visit:					
When did this problem first occur?					
Have you ever had this problem before? Y N					
Have you previously been treated for this problem? Y N Doctor's Name:					
Have you previously been to a chiropractor? Y N When?					
ABOUT YOUR HEALTH In the past year have you had any of the following:					
Back or neck pain? Y N					
Pains in the legs or arms? Y N					
Headaches? Y N					
Asthma? Y N					
Allergies? Y N					
Earaches? Y N					
Falls from a bicycle, skateboard, scooter, rollerblades or similar? Y N					
Do you ever have a problem with bedwetting? Y N					
Have you ever been in a motor vehicle accident? Y N					
Have you ever had any broken bones? Y N					
Have you ever had any surgeries? Y N					
Are your currently taking any medications? Y N					
Do you have any other health problems? Y N					



Date: ____/___/_





Patient or Guardian Signature: ___

ABOUT YOUR LIFESTYLE What grade are you in at school?					
How do you carry your school books?					
How heavy is your school backpack?					
What sports to you play?					
What hobbies do you have?					
How many hours each day do you watch TV?					
How many hours each day do you spend using a computer?					
How often do you play video games?					
On average, how many hours of sleep do you get each night?					
Are there any smokers in your family? Y N					
Do you feel stressed out? Y N					
Do you have trouble reading the board in class? Y N					
Do you ever have blurred vision? Y N If yes, do you wear contact lenses?					
Do you sometimes get headaches when you read? Y N					
ABOUT YOUR DIET What do you usually eat for breakfast?					
What do you usually eat for lunch?					
What do you usually eat for dinner?					
What snacks do you have after school?					
What is your favorite food?					
How much water do you drink each day?How many sodas do you drink each day?					
How often do you eat fast food items?					
All information provided within this document is true and accurate to the best of my knowledge.					

Insurance Questionnaire

The following questions are necessary so that we may properly file your insurance for you. The se questions are taken directly from the insurance form that we must fill out and file for you. Please answer as fully as possible.



1. Type of insurance: Medicare	Me d ic a id	Group Hea	alth PlanOther_	
2. Insure d's ID Numb e r				
3. Pa tie nt Na me:				
4. Insure d				
Na m e :				
5. Insure d date of birth:	SSN: _		Ma le	Fe m a le
6. Insure demployername or Scho	ol			
na me:				
C ity	Sta te	Zip	Tel#	
7. Insure d's Address (if same as pa	tie nt put "sa me	"):		
C ity	Sta te	Zip	Tel#	
8. Patient Status: Single Manie	d Other	Employed	Full-time Student	Part-time Student
9. Is the condition we are treating	re lated to cum	e nt or pre vio u	semployment? Yes_	No
10. Is the condition we are treating	g related to an	auto accider	nt? Ye s No	
11. Is the condition we are treating	g related to an	othertype of	accident? Yes No	0
12. Is the re a nother health be nefit	p la n? Ye s	No If ye s,	list:	
Patient's or Authorized Person's Sig process my insurance claim. This is Signed:	to serve as a lo	ong-term auth	no riza tio n c a rd .	
Insure d's or Authorize d Person's Sig described on the insurance form. writing. I agree to pay for services payment in full at this office. Signed:	This a utho riza tion not covered by	on is to apply y insurance a	to alloccasions of sen nd understand that I	vice until it is revoked in am ultimately responsible for
MEDIC ARE ONLY				
All doctors have been instructed t	•	-	•	
1. Do you or your spouse work for a				
2. Are you entitled to Medicare be	cause of End S	Stage RenalD	Pise a se? Ye s No	
3. Is the illness or injury the result of	an accident o	rillness that o	ccurred atwork? Yes	No
4. Is this illness or injury the result of	an accidento	r o the r injury?	Ye s No	
5. Has the treatment for this accid	entorillnessbe	en a utho rize d	l by the Ve te ra n's Ad	m in istra tio n? Ye s No
6. Are you entitled to any benefits	under the Fede	e ra l Bla c k Lun	g Program? YesNo	0
7. Do you have a Medicare Medig	gap Policy? Yes	s No Na	me of Company	
8. Do you have a Medicare Supple	e me nt Po lic y?	(Po lic y pro vid	ed by employeryou r	e tire d from)? Ye s No