CARLSON
Family Chiropractic, P.C.

Pediatric Patient Intake Form

Date: _____ Social Security #: _____-_____-_____ Patient #: _____

First Name: _____ Middle Name: _____ Last Name: _____

Name of Parents/Guardians: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Parent Cell Phone: _____

Email Address:_____

Birth Date: ____/_____/____ Age: _____ Sex: M F # of siblings: _____

Race/Ethnicity: ____White/Caucasian _____ Hispanic/Latino/Spanish Origin _____ Black/African American

___ Asian ____ American Indian _____ Native Hawaiian ____ Other: _____

Language: _____ English _____ Spanish _____ Other: _____

In case of an emergency please contact: _____ Phone: _____-_____-_____

How did you hear about our office? _____

Reason for seeking chiropractic care: _____

_____

Pregnancy History

Did you have a birth plan? Yes No Was it a planned pregnancy? Yes No

Did you receive prenatal care from an: OB/GYN Midwife Both Other: _____

How long was the pregnancy term? (42 weeks): _____ Did you take birthing classes? Yes No

Did you have any medical diagnoses during pregnancy? Yes No What: _____

_____

What in-utero testing was done? Yes No Did you have any x-rays taken during the pregnancy? Yes No

Did you have an ultrasound? Yes No How many? _____ How long? _____

Did you experience morning sickness? Yes No How long? _____

Were you under emotional stress during the pregnancy? Yes No

Were you supported through your pregnancy? Yes No Did you enjoy being pregnant? Yes No

What medications did you take or were prescribed during your Pregnancy? _____

Did you smoke cigarettes during your pregnancy? Yes No How often? _____

Did you drink alcohol during your pregnancy? Yes No How often? _____

Did you exercise during your pregnancy? Yes No How often? _____

Did you have any caffeine during your pregnancy? Yes No How often? _____

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Patient Name: _____ Patient #: _____

Birth History

Where did you deliver? Hospital Birth Center Home Other: _____

How did you deliver? Vaginal or Cesarean Was it natural or induced? _____

Were instruments used? Yes No If so, what: (vacuum or forceps) _____

Were you given any medications or epidural during the labor? _____

Were there any complications with the labor or delivery? Yes No Explain: _____

_____

What was the neonate's position? Breech Face Up Face Down

How long was the labor/delivery? _____

When was the cord cut? Immediately After _____ minutes

What was the APGAR score? _____/_____ Explain if low: _____

Did the neonate cry immediately after birth? Yes No If not, how long after: _____

What was the strength of the cry? Strong Moderate Weak

Was intensive care necessary? Yes No Was the neonate given formula in the hospital? Yes No

Did you breastfeed? Yes No How long? _____

Were vaccinations administered? Yes No Which ones? _____

_____

Head circumference at birth? _____ Length at birth? _____

Weight at birth? _____ Was he circumcised? Yes No

Were any antibiotics administered to you? Yes No

Were any antibiotics administered to the neonate? Yes No

Experience with Chiropractic

Has the child been seen by a chiropractor before? Yes No Who? _____

When? _____ Reasons for Visit: _____

How did the child respond? _____ Did they take X-Rays: Yes No

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Patient Name: _____ Patient #: _____

Current History

Name of Pediatrician: _____ Date of last Visit: ____/____/_____

Reason: _____

Number of doses of Antibiotics your child has taken during the past six months: _____

Total does of Antibiotics during his/her lifetime: _____ List: _____

Number of Prescription medications your child has taken during the past six months: _____

Total number of prescriptions during his/her lifetime: _____ List: _____

Introduced to solids at: _____ Months Cows milk at _____ Months

Food/Juice Allergies or Intolerances: Yes No List: _____

According to the National Safety Council, approximately 50% of all children fall head first from a high place during the first year of their life (i.e. a bed, changing table, stairs, etc.) Was that true of your child? Yes No

Is/Has your child ever been involved in any high impact or contact type sports (i.e. soccer, football gymnastics, baseball, cheerleading, martial arts)? Yes No List: _____

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

Has your child ever been seen in the ER? Yes No Explain: _____

Prior Surgery: Yes No List: _____

Has your child ever suffered from: (Check all that apply)

- ☐ Dizziness
- ☐ Backaches
- ☐ Heart Trouble
- ☐ Chronic Earaches
- ☐ Diabetes
- ☐ Tuberculosis
- ☐ Hypertension
- ☐ Cold/Flu
- ☐ Arthritis
- ☐ Headache
- ☐ Asthma
- ☐ Allergies
- ☐ Digestive Disorder
- ☐ Sinus Trouble
- ☐ Constipation
- ☐ Anemia
- ☐ Rheumatic Fever
- ☐ Diarrhea
- ☐ Poor Appetite
- ☐ Hyperactivity
- ☐ Behavioral Problems
- ☐ Bed wetting
- ☐ Convulsions
- ☐ Paralysis
- ☐ Muscle Jerking
- ☐ Fainting
- ☐ Walking Problems
- ☐ Broken Bones
- ☐ Ruptures/Hernias
- ☐ Neck Problems
- ☐ Arm Problems
- ☐ Leg Problems
- ☐ "Growing Pains"
- ☐ Joint Problems
- ☐ Blood Disorders
- ☐ Stomach Aches

Are there any other conditions or symptoms that were not mentioned above? _____

Number of hours sleeping per night: _____ Quality of sleep: Good Fair Poor

Has your child had any of the following diseases?

Chicken Pox N/Y Age_____ Mumps N/Y Age_____ Rubella N/Y Age_____

Whooping cough N/Y Age_____ Rubeola N/Y Age_____

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Patient Name: _____ Patient #: _____

Family History

Many health problems are the result of hereditary weaknesses, thus information about your family members will give us a better picture of your overall health.

Name	Relationship	Past & Present Problem

Terms of Acceptance

When a patient seeks chiropractic care and we accept such a patient for care, it is essential for both to be working towards the same objective. Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be able to attain it. This will prevent any confusion or disappointment.

An **adjustment** is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments to the spine.

Health is a state of optimal physical, mental and social well being, not merely the absence of disease or symptoms.

Vertebral Subluxation is a misalignment of one or more of the joints of the body. This may or may not cause pain. This also will result in alteration of nerve function and interference of the transmission of nerve impulses, lessening the body's innate ability to heal and achieve optimal health.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic evaluation, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. One method is specific adjusting to the correct vertebral subluxation.

I, _____ have read and fully understand the above statement.

Any questions regarding the Doctor's objectives pertaining to care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis.

Parent or Guardian Signature: _____ Date: _____

CA Signature: _____ Date: _____

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Authorization for Care & Privacy Policy

I hereby authorize the doctors to work with my condition through the use of spinal adjustments, as he or she deems appropriate. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. The Doctor(s) will not be held responsible for any medical diagnosis. I also understand that if I suspend or terminate my care, any fees will become immediately due and payable. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I understand that Carlson Family Chiropractic, P.C. (CFC) will prepare any necessary reports and forms to assist me in collecting from the insurance company and that any amount authorized to be paid directly to CFC and will be credited to my account upon receipt. If my account is delinquent for more than 90 days, I understand my account will be sent to a collection agency. If my account is sent to the collection agency, I agree to pay all collection fees and costs, including but not limited to, attorney's fees added for the collection of my account, whether or not suit is filed.

Patient's Initials: _____

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. Disclosure of my protected health information without authorization is strictly limited to defined situations that include: emergency care, quality assurance, public health, research and law enforcement activities. I understand that this information can and will be used to: conduct, plan and direct my treatment; follow up with other healthcare providers who are involved in my treatment directly or indirectly; and to obtain payment from third party payers. I understand that any other disclosures for the purposes of treatment, payment or practice operations will be made only after obtaining my consent. I know that:

- I may request restrictions on the disclosures of my health records
- I may inspect and receive copies of my records for a fee within 14 days with a request
- I may request to view changes to my records.

Patient's Initials: _____

I give permission to the doctors of CFC to use my address, phone number, email, and clinical records to contact me with appointment reminders, missed appointments, birthday cards, holiday related cards and information about treatment alternatives or other health related information. If CFC contacts me by phone, I give them permission to leave a message with a family member or on my answering machine or voicemail. I also give my permission to use my name and photo in testimonial format (if applicable). The display of any name or photo would ONLY be done after first receiving verbal authorization.

Patient's Initials: _____

I give CFC permission to treat me in a semi-open room where other patients are also being treated. I am aware other persons in the office may overhear some of my protected health information during the course of care. Should I need to speak with the doctor at any time in private, the doctor will provide a room for these conversations.

Patient's Initials: _____

You have the right to revoke authorization at any time. However, your written request to revoke this authorization is not effective to the extent that we have provided services or taken action in reliance on your authorization. You may revoke this authorization by mailing or hand delivering a written notice to CFC. The written notice must contain the following information:

1. Your name, SS number, and your date of birth
2. A clear statement of your intent to revoke this authorization
3. The date of your request and your signature

The revocation is not effective until CFC receives it. You have the right to refuse to sign this authorization. If you refuse to sign this authorization, Carlson Family Chiropractic, P.C. has the right to refuse to provide care.

Patient's Initials: _____

A copy of this signed authorization will be provided to you upon request. This authorization shall remain in effect unless revoked in writing by the patient. By signing this form I am giving Carlson Family Chiropractic, P.C. permission to use and disclose my protected health information in accordance with the directives listed above.

Patient Name (Print): _____ Patient #: _____

Parent or Guardian Name (Print): _____ Relationship: _____

Parent or Guardian Signature: _____ Date: _____

CA Signature: _____ Date: _____