HERRMANN FAMILY CHIROPRACTIC

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Pediatric Intake Form

Patient Information:

Name:_____ Date: _____/_____/_____
First Middle Last

Preferred Name:_____ Date of Birth _____/_____/_____ Gender ☐ M ☐ F

Cell (_____)_____-_____ Home/Other (_____)_____-_____Email:_____

Address:_____
Street City State Zip

Parent(s)/Guardian(s) Name(s):_____

Emergency Contact:_____ Relation:_____ Phone (_____)_____-_____

School Information: School Name:_____ Grade/Level:_____

Current Sports & Extra Curricular Activities: _____

_____

Reason(s) for Visit:_____

_____

Describe your child's symptoms: _____

_____

Rate his/her discomfort on a scale of 0 (no discomfort) to 10 (worst possible discomfort):_____

When did this begin? ____/____/____ Since it started, has it gotten: ☐ better, ☐ worse, or ☐ stayed the same?

How did this begin?:_____

_____

What makes it better (ice, heat, stretching, medication)?_____

What makes it worse (sitting, standing, movement)?_____

Has s/he experienced this before? ☐No ☐Yes (explain)_____

_____

Have you sought care from another provider for this concern? ☐No ☐Yes (explain)_____

_____

Chiropractic Experience: Has your child been adjusted before? ☐Yes ☐No

Date of last adjustment: _____/_____/_____ Were X-Rays performed in the last 2 years? ☐Yes ☐No

Chiropractor:_____ Location:_____
Chiropractor and/or office name City, State

How did you hear about our office? ☐Website ☐Facebook ☐Email ☐Drive/Walk by ☐Insurance Website
☐Family/Friend:_____☐Community Event: _____☐Other: _____

Child's Personal Health History (if known):

Child's birth was: Labor:_____ hours Pushing: _____ minutes

☐ at a hospital ☐ at a birthing center ☐ at home ☐ other:_____

☐ Natural vaginal (with no interventions)

☐ Vaginal with interventions (please select all that apply)

☐ Induction ☐ Pain medication ☐ Epidural ☐ Episiotomy ☐ Vacuum extraction ☐ Forceps

☐ C-section: ☐ Scheduled ☐ Emergency

Please explain any interventions/complications:_____

_____

Weeks Gestation: _____ Birth Wt:_____ Birth Ht: _____Current Wt: _____ Current Ht: _____

Was your child in the NICU? ☐ No ☐ Yes. Why and how long?_____

Please list any maternal illnesses during pregnancy:_____

_____

Is/was your child breastfed? ☐ No ☐ Yes. How long?_____ Prefers: ☐ Right side ☐ Left side ☐ Neither

Latch is/was: ☐ Normal ☐ Difficult ☐ Painful ☐ Shallow ☐ Noisy ☐ Clicking ☐ Loud gulps ☐ Weak ☐ Leaking

Other breastfeeding concerns:_____

Has your child received vaccinations? ☐ No ☐ Yes, some ☐ Yes, all required

Primary Care Physician:_____ Date of last physical: ____/____/____
Physician and/or office name

Current Illnesses:_____

Previous illnesses:_____

Current medications: (Rx & OTC)_____

Supplements/Vitamins:_____

Personal Incident History (*include relative dates or ages*):

Surgeries ☐No ☐Yes (explain)_____

Broken Bones ☐No ☐Yes (explain)_____

Sprains/Strains ☐No ☐Yes (explain)_____

Hospitalizations ☐No ☐Yes (explain)_____

Auto Accident ☐No ☐Yes (explain)_____

Struck Unconscious ☐No ☐Yes (explain)_____

Other Injuries_____

Health Checklist (*mark all that apply, past and present*):

Musculoskeletal
- ☐ Ankle Pain/Injury
- ☐ Arthritis (Type:_____)
- ☐ Back Pain
- ☐ Cramps
- ☐ Disc Herniation
- ☐ Dislocation(Location:_____)
- ☐ Elbow Pain/Injury
- ☐ Knee Pain/Injury
- ☐ Muscle Pain
- ☐ Muscle Spasm
- ☐ Neck Pain
- ☐ Poor Posture
- ☐ Plantar Fasciitis
- ☐ Scoliosis/Spinal Curves
- ☐ Shoulder Pain/Injury
- ☐ Sprains/Strains
- ☐ TMJ Dysfunction/Syndrome
- ☐ Torticollis ("Wry Neck")
- ☐ Whiplash
- ☐ Wrist Pain/Injury

Neurological
- ☐ ADD
- ☐ ADHD
- ☐ Anxiety
- ☐ Autism Spectrum Disorder
- ☐ Behavioral Outbursts
- ☐ Cerebral Palsy
- ☐ Concussion/Head Injury
- ☐ Depression
- ☐ Epilepsy/Seizures
- ☐ Fibromyalgia
- ☐ Insomnia/Sleep Difficulties
- ☐ Loss of Balance
- ☐ Loss of Consciousness
- ☐ Loss of Hearing
- ☐ Loss of Memory
- ☐ Loss of Smell/Taste
- ☐ Loss of Vision
- ☐ Migraines/Headaches
- ☐ Multiple Sclerosis
- ☐ Nervous Tics
- ☐ Night Terrors
- ☐ Numbness (Location:_____)
- ☐ OCD
- ☐ Panic Attacks
- ☐ PTSD
- ☐ Sensory Processing Disorder
- ☐ Sensory-Seeking Behaviors
- ☐ Sleepwalking
- ☐ Speech Issues
- ☐ Tourette's Syndrome
- ☐ Tremors
- ☐ Vertigo/Dizziness

Head/Neck
- ☐ Cataracts
- ☐ Congestion
- ☐ Difficulty nursing/Painful latch
- ☐ Drooling excessively
- ☐ Ear Infections
- ☐ Eye Pain/Problems
- ☐ Frequent Colds
- ☐ Glasses/Contacts
- ☐ Hearing Aid(s)
- ☐ Mouth-Breathing
- ☐ Nosebleeds
- ☐ Plagiocephaly (flat heat)
- ☐ Sinus Infection
- ☐ Snoring
- ☐ Strep throat
- ☐ Strabismus ("Lazy Eye")
- ☐ Swollen Tonsils/Adenoids
- ☐ Tinnitus/Ear Ringing
- ☐ Tongue or Lip Tie

Heart/Lungs/Chest/Circulation
- ☐ Anemia
- ☐ Asthma
- ☐ Bronchitis
- ☐ CHF
- ☐ Cold Hands/Feet
- ☐ Congenital Heart Defect
- ☐ High Blood Pressure
- ☐ Irregular Heartbeat/Murmur
- ☐ Shortness of Breath
- ☐ Sleep Apnea
- ☐ Swelling of Ankles/Feet

Gastrointestinal
- ☐ Acid Reflux/Heartburn
- ☐ Celiac Disease
- ☐ Constipation
- ☐ Crohn's Disease
- ☐ Diarrhea
- ☐ Encopresis
- ☐ Food Sensitivities
- ☐ Gas Pain/Bloating
- ☐ Indigestion
- ☐ Irritable Bowel Syndrome
- ☐ Stomach Pains
- ☐ Ulcer
- ☐ Ulcerative Colitis

Genitourinary
- ☐ Bedwetting
- ☐ Incontinence
- ☐ Irregular Menstrual Cycle
- ☐ Kidney Disease
- ☐ Kidney Infection
- ☐ Kidney Stones
- ☐ Painful Urination
- ☐ PMS/PMDD
- ☐ Urinary Frequency
- ☐ UTI

Skin
- ☐ Acne
- ☐ Cradle Cap
- ☐ Eczema
- ☐ Psoriasis
- ☐ Skin Sensitivity

Systemic/Endocrine/Other
- ☐ Allergies (Type:_____)
- ☐ Autoimmune Disease
- ☐ Bleeding Disorder
- ☐ Bruise Easily
- ☐ Cancer (Type:_____)
- ☐ Colic
- ☐ Diabetes (Type:_____)
- ☐ Fatigue
- ☐ Hernia (Type:_____)
- ☐ Immune Deficiency
- ☐ Jaundice
- ☐ Muscular Dystrophy
- ☐ Thyroid Condition

Other:_____

_____

_____

Social History:

Exercise:	☐No ☐Yes, _____	Minutes	per	☐Day	☐Week	☐ Month
Fruits/Vegetables:	☐No ☐Yes, _____	Servings	per	☐Day	☐Week	☐ Month
Processed Foods:	☐No ☐Yes, _____	Servings	per	☐Day	☐Week	☐ Month
Restaurants:	☐No ☐Yes, _____	Meals	per	☐Day	☐Week	☐ Month
Soda/Pop:	☐No ☐Yes, _____	Servings	per	☐Day	☐Week	☐ Month
Water:	☐No ☐Yes, _____	Ounces	per	☐Day	☐Week	☐ Month

Family Health History (*include significant diseases and genetic disorders, if known*):

	Condition(s)	Age	Alive or Deceased
Mother			☐ Alive ☐ Deceased
Father			☐ Alive ☐ Deceased
Sibling(s)			☐ Alive ☐ Deceased
Maternal Grandmother			☐ Alive ☐ Deceased
Maternal Grandfather			☐ Alive ☐ Deceased
Paternal Grandmother			☐ Alive ☐ Deceased
Paternal Grandfather			☐ Alive ☐ Deceased
Other			☐ Alive ☐ Deceased

Please provide any additional information about your child's health:

_____

_____

_____

_____

I certify that I am the parent or legal guardian of the child listed above. I have read/understand the included information and certify it to be true and accurate to the best of my knowledge. I consent to the collection and use of the above information to Herrmann Family Chiropractic. I authorize this office and its staff to examine and provide care for my child's condition as the doctors see fit. I hereby authorize the doctor to release all information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursement of charges incurred by my child. I grant the use of my signed statement of authorization with my signature for required insurance submissions. I understand and agree that all services rendered to my child will be charged to me, and I am responsible for timely payment of such services. I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and my child. I understand that fees for professional services will become immediately due upon suspension or termination of my child's care.

Printed name of parent/guardian:_____ Relation to patient:_____

Signature of parent/guardian: _____ Date:_____/_____/_____

INFORMED CONSENT IN THE STATE OF IOWA

FROM THE PATIENT

You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether to undergo such care after being advised of the known risks. This disclosure is not meant to frighten or alarm you. It is simply to make you better informed in order that you may give or withhold your consent.

INTRODUCTION

The professions of chiropractic, dentistry, medicine and surgery, nursing, optometry, osteopathy, osteopathic medicine and surgery, pharmacy, physical therapy, podiatry, psychology, and others are regulated in the state of Iowa under Iowa Code Chapter 147. Patient care and treatment provided by those above listed professions have known risks, which may include death, brain damage, quadriplegia, paraplegia, the loss or loss of function of any organ or limb, or disfiguring scars associated with such care and treatment.

Chiropractic is a science which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) of the body as the relationship may affect the restoration and preservation of health. For your information, the following is routinely furnished to all who consider chiropractic care and treatment in this office.

NATURE AND PURPOSE OF CHIROPRACTIC

Adjustments are made by chiropractors to correct spinal and extremity joint subluxations. One of the most common disturbances to the nervous system is the vertebral subluxation. This condition exists where one or more vertebrae in the spine are misaligned sufficiently to cause interference and/or irritation of the nervous system. The primary goal in chiropractic health care is the removal of nerve interference caused by such subluxation(s). This is done with a chiropractic adjustment following a chiropractic examination which may include, but is not limited to spinal and physical examination, orthopedic and neurologic testing, palpation, specialized instrumentation, radiology examinations, and laboratory tests.

An adjustment is the application of a quick precise movement over a very short distance to the spine or extremity. There are a number of different adjusting techniques, some utilizing specially designed equipment. Adjustments are usually performed by hand but may be performed by hand-guided instruments. In addition, physiotherapy and/or rehabilitative procedures may be included in the management protocol.

Not only should you understand the benefits of chiropractic care and treatment in restoring and maintaining good health, but also you should be aware of the existence of some inherent risks and limitations. These are seldom enough to contraindicate care but should be considered in making the decision to receive chiropractic care. All health care procedures, including those used to varying degrees, have some risks associated with them. Risks associated with some chiropractic adjusting procedures may include musculoskeletal sprain/strain, neurological injury, fracture, vertebral artery syndrome (VAS) including stroke and perhaps death through complicating factors. Risks associated with physiotherapy may include not only the foregoing but also allergic reaction, muscle and/or joint pain.

AUTHORIZATION FOR CHIROPRACTIC CARE AND TREATMENT

I have been informed of the nature and purpose of the chiropractic care, the possible consequences of the care, and the risks of the care, including the risk that the care may not accomplish the desired objective. Reasonable alternative treatments have been explained, including the risks, consequences, and probable effectiveness of each and I have been advised of the possible consequences if no care is provided. I acknowledge that no guarantees have been made to me concerning the results of the care and treatment.

I HAVE READ THE ABOVE PARAGRAPHS. I UNDERSTAND THE INFORMATION PROVIDED. THE INFORMATION PROVIDED HAS BEEN EXPLAINED TO ME AND ALL QUESTIONS WHICH I HAVE ASKED HAVE BEEN ANSWERED TO MY SATISFACTION. HAVING THIS KNOWLEDGE, I KNOWINGLY AUTHORIZE HERRMANN FAMILY CHIROPRACTIC TO PROCEED WITH CHIROPRACTIC CARE AND TREATMENT.

PATIENT'S SIGNATURE _____ **DATE** _____/_____/_____

WHEN THE PATIENT IS A MINOR OR UNABLE TO CONSENT:

PATIENT'S NAME _____ **RELATIONSHIP TO PATIENT** _____

SIGNATURE OF PERSON AUTHORIZED TO SIGN FOR PATIENT _____

PARENT/GUARDIAN PRINTED NAME _____ **DATE** _____/_____/_____

PLEASE INDICATE THAT YOU HAVE READ AND UNDERSTAND THE FOLLOWING BY INITIALING AND SIGNING BELOW:

Patient Health Information Consent

_____You have the right to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we begin any health care operations, we require that you read, initial, and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information, we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent needs only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff have been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, our office has the right to refuse to give care.

X-Ray Consent

_____This is to certify that the doctors have my permission to perform an X-ray evaluation if he or she finds X-Ray evaluation necessary. To the best of my knowledge, I am not pregnant, and I have been advised that x-ray can be hazardous to an unborn child.

Insurance and Personal Financial Responsibility

_____Your insurance company will only pay for services that they determine are medically necessary. As a patient you must understand that some or all services provided for your care might not be covered by your contract benefits. You as a patient are liable for all charges that your plan does not cover. We cannot guarantee your insurance coverage, even if the office attempts to confirm your benefits and eligibility. Final approval of coverage is based on the explanation of benefits after the claim has been filed. I have been notified by my doctor that my insurance may not cover all the services provided for my care. If payment is denied for these services, I agree to be personally and fully responsible for payment. Any co-pay, coinsurance, or deductible is due at the time of service. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the office staff will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Herrmann Family Chiropractic will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

Missed Appointment/No-Show Policy

_____**Appointments that are not cancelled or rescheduled prior to your appointment time may be subject to a missed visit fee of $40. This fee is not covered by insurance and is due before your next visit.** Appointment times are reserved for you and the doctors make every effort to accommodate your needs. When you do not arrive for a scheduled appointment, it creates an unused appointment time that could have been used for another patient. Your missed appointments not only affect the doctors' schedules but, more importantly, alter your progression of care. Please call to reschedule or cancel 24 hours prior to your scheduled appointment.

I HAVE READ THE ABOVE STATEMENTS. I UNDERSTAND THE INFORMATION PROVIDED. THE INFORMATION PROVIDED HAS BEEN EXPLAINED TO ME AND ALL QUESTIONS WHICH I HAVE ASKED HAVE BEEN ANSWERED TO MY SATISFACTION. HAVING THIS KNOWLEDGE, I KNOWINGLY AUTHORIZE HERRMANN FAMILY CHIROPRACTIC TO PROCEED WITH CHIROPRACTIC CARE AND TREATMENT.

PATIENT'S SIGNATURE _____ **RELATIONSHIP TO PATIENT** _____ **DATE** _____/_____/_____