Family Health and Wellness
CHIROPRACTIC
TRUSTED BY THE ADJUSTED

Pediatric Intake Form (Birth to 12 years)

Patient Information:

Child's Name: _____ Parent's Name: _____

Address: _____ City: _____ State: _____

Zip: _____ Social Security #: _____Gender: M F

Race/Ethnicity:_____Birth Date:_____ Age:_____ Home Number:_____

Parent's Cell Number: _____ Parent's Cell Carrier: _____ (needed if you want to receive emails or text messages) Parent's Email: _____ (needed if you want to receive emails or text messages)

How would you like to be contacted: □ Home Phone □ Cell Phone □ Text □ Email

Name of Emergency contact: _____

Address of contact (if not the same as yours): _____

Phone # of contact: _____

How were you referred to our office? _____

Child's Pediatrician: _____

When doctors work together it benefits you. May we have your permission to update your child's pediatrician regarding their care at this office? _____

Please check any and all insurance coverage that may be applicable in this case:
□ Major Medical □ Worker's Compensation □ Medicaid □ Medicare □ Auto Accident
□ Medical Savings Account & Flex Plans □ Other

Has your child been checked by a Doctor of Chiropractic? ☐ Yes ☐ No
If yes, please provide the name of the office & doctor: _____

Were x-rays taken? ☐ Yes ☐ No

Prenatal History:

Did you have any complications and when? _____

Did you smoke? ☐ Yes ☐ No

Did you consume alcohol? ☐ Yes ☐ No

Did you take medication? ☐ Yes ☐ No
Reason for medication? _____

Birth History:

Did you have ultrasound during the pregnancy? ☐ Yes ☐ No
What was the frequency? _____

Place of birth: ☐ Home ☐ Birthing Center ☐ Hospital

Provider: ☐ Midwife ☐ OBGYN ☐ Other

Type of Birth: ☐ Vaginal ☐ C-Section

Were pain medications used? ☐ Yes ☐ No

Was labor induced? ☐ Yes ☐ No
If yes, why? _____

Birth trauma? ☐ Doctor Assisted ☐ Twisting and/or Pulling ☐ Vacuum Extraction ☐ Forceps
Newborn Trauma (medical procedures and test): _____

Did your child have a misshapen skull/head? ☐ Yes ☐ No

Were there purple markings on their face? ☐ Yes ☐ No

Did you breast feed your child? ☐ Yes ☐ No

Does your child prefer one breast over the other? ☐ Yes ☐ No

If yes, which side? ☐ Right ☐ Left

Does your child have any allergies? ☐ Yes ☐ No
If yes, please list: _____

Has your child been immunized? ☐ Yes ☐ No

Did your child have any negative reaction to the vaccination? ☐ Yes ☐ No

Has your child ever had any surgeries? ☐ Yes ☐ No
If yes, please elaborate: _____

Has your child been on antibiotics? ☐ Yes ☐ No
If yes, how often and what for? _____

Is your child currently taking any medication? ☐ Yes ☐ No

Is your child currently taking any vitamins? ☐ Yes ☐ No

Baby/Toddler (0-4):
Have any of the following occurred?

☐ Falling from a changing table ☐ Frequent crying spells ☐ Tumble down stairs ☐ Involvement in MVA

☐ Fall out of crib ☐ Fall off playground equipment ☐ Frequent ear infections ☐ Tonsillitis

☐ Reaction to vaccines ☐ Frequent fevers ☐ Frequent diarrhea ☐ Constipation ☐ Sleeping problems

☐ Repeated infections or colds ☐ Colic ☐ (+ or -) weight gain

☐ other (please explain): _____

Child (5-12):
Has any of the following occurred?

☐ Fall from a tree ☐ Fall off of a bicycle ☐ Sports accident ☐ Car accident ☐ Stomach pains

☐ Scoliosis ☐ Bed wetting ☐ Fall on playground ☐ Hyperactivity/Autism ☐ Learning difficulties

☐ Asthma ☐ Allergies ☐ Leg/Knee pain

☐ Other (please explain): _____
Which of the above bothers your child the most? _____
When did it begin? _____

Is it getting worse? ☐ Yes ☐ No

Effect on activity? ☐ Not at all ☐ Somewhat ☐ Always

Is the pain: ☐ Constant ☐ Intermittent ☐ Cyclic

Does your child participate in any of the following?

☐ Soccer ☐ Football ☐ Gymnastics ☐ Karate

☐ Hockey ☐ Lacrosse ☐ Basketball ☐ Dance

☐ Wrestling ☐ Baseball/Softball ☐ Volleyball ☐ Tennis

☐ Swimming ☐ Rugby ☐ Other: _____

How would you rate your child's diet? ☐ Well balanced ☐ Average ☐ High sugar/processed foods

Does your child consume artificial sweeteners? ☐ Yes ☐ No

Fluoridated water? ☐ Yes ☐ No

Number of hours your child sleeps? _____hours/day

Sleep quality? ☐Good ☐ Fair ☐ Poor

Patient Acknowledgement and Receipt of Notice of Privacy Practices Pursuant to HIPAA and Consent for Use of Health Information

Name_____ date _____
(Print Patient's Name)

The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant to HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request.

The undersigned does hereby consent to use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State Law and Federal Law.

Dated this _____ day of _____, 20_____

If patient is a minor or under a guardianship order as defined by State Law:

By_____
Signature of Parent/ Guardian (Circle One)

Patient Health Information Consent Form

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your record 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.

- The patient understands and agrees to allow this chiropractic office use their Patient Health Information (PHI) for the purpose of treatment, payment, health care 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.
- The patient has the right to examine and obtain a copy of his or her own health records at the time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restriction on the use of their PHI. Our office is not obligated to agree to those restrictions.
- A Patients' written consent need only be obtained one time for all subsequent care given the patient in this office.
- 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 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.
- For your security and right to privacy, all staff has been trained in the area of patient's record privacy and a privacy official has been designated to enforce those procedures.
- Patients have the right to file a formal complaint with or privacy official about ay possible violations of these polices and procedures.
- If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

DATE: _____ _____

Printed Name

_____

Signature of Parent or Guardian

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INFORMED CONSENT

PATIENT NAME: _____

Clinic Name: Family Health and Wellness Chiropractic

Doctor's Name: Dr Kari J Skertich

Address _____

Phone: _____ Fax: 618-391-0202

I will use my hands or a mechanical instrument upon your body in such a way as to move your joints. This procedure is referred to as "Spinal Manipulation" or Spinal Adjustment". As the joints in your spine are moved, you may experience a "pop" as part of the process.

There are certain complications that can occur as a result of a spinal manipulation. These compilations include, but are not limited to: muscle strain, cervical myelopathy, disc and vertebral injury, fractures, strains and dislocations, Bernard-Horner's Syndrome (also known as oculosympathethetic palsy), costovertebral strains and separation. Rare complications include, but are not limited to, stroke. The most common complication or complaint following spinal manipulation is an ache or stiffness at the site of adjustment. I am also aware of the complications that can arise from the physical modalities hereby used in the office for my care.

I am aware of these complications, and in order to minimize their occurrence I will take precautions. These precautions include, but are not limited to, my taking a detailed clinical history of you and examining you for any defect which would cause a complication. This examination may include the use of x-rays. The use of x-ray equipment may pose a risk if you are pregnant. If you are pregnant, you should tell me when I take you clinical history.

I hereby authorize Dr. Kari Skertich and whomever she may designate as her assistants to administer treatment as she so deems necessary.

DATE: _____

_____
Printed Name

_____
Signature of Parent or Guardian