TIMPVIEW CHIROPRACTIC

CHILD INTAKE FORM

PERSONAL INFORMATION

First Name _____ M.I. _____ Last Name: _____

Preferred Name: _____

Birth Date: _____ Gender: M / F Email: _____

Parents' Names: _____

Address: _____ City, State, Zip: _____

Primary Phone: (_____) _____-_____ Alternate Phone: (_____) _____-_____

Women of childbearing age only: Are you pregnant? Y / N / Maybe (explain)_____

Of Siblings: _____ Sibling(s) names and ages: _____

_____

Who referred you to our office? _____

PERMISSION TO TREAT A MINOR

I, (Parent/Guardian) _____, give Timpview Chiropractic permission to examine, x-ray (if indicated), and treat the patient named above.

Parent/Guardian Signature: _____ Date: _____

REASONS FOR SEEKING CARE

What are your reasons for seeking care at Timpview Chiropractic? _____

_____

When did this begin? (If applicable) _____

What is this affecting that is MOST important in your child's life?_____

_____

What other health professionals have you consulted for this condition? _____

Has your child ever seen a chiropractor before? Y / N Approximate date of last adjustment: _____

Doctor/clinic name:_____ Reason for change: _____

What else would you like us to know about your child? _____

_____

_____

Simple, specific chiropractic adjustments have been shown to improve the following: motor coordination, skeletal muscle strength, cortical stimulation of the brain, cognitive function, emotional balance, fall prevention, and autonomic regulation. In other words, the purpose of chiropractic is to help the body to balance and regulate itself better.

In 2015 the Journal of American Osteopath Association studied 100 newborns within 72 hours of birth. They concluded that the neck and base of the skull have a 91-99% chance of being injured during birth. They found the risk of injury increased with every hour spent in labor.

~J Am Osteopath Assoc. 2015 Nov;115(11):654-65

THE PATIENT'S PRENATAL HISTORY

Location of Birth: _____ Hospital Home Birthing Center Other:_____

How long was labor total? _____ How long did you push? _____

Birth Weight: _____ Birth length: _____

Did any of the following happen at birth?

❑ C-section delivery ❑ Doctor pulled or twisted baby ❑ Epidural
❑ Forceps or Vacuum extraction ❑ Premature Delivery ❑ Pitocin (labor induced)

Describe any of the above plus any additional complications experienced during labor & delivery: _____

_____

During pregnancy, did you use any drugs, tobacco, alcohol, and/or medications? If yes, please list: _____

_____

Did you experience any illnesses while pregnant? Y / N If yes, explain: _____

How many ultrasounds did you receive during the pregnancy? _____

CURRENT HEALTH STATUS

Did you breastfeed the baby? Y / N If yes, how long? _____

Did you formula feed? Y / N If yes, what brand? _____

At what age did you introduce: Solids: _____ Cow's milk: _____

Has your child fallen from a high place during their first year of life? Y / N _____

Has your child ever been hospitalized or had surgery? Y / N _____

Please list any sports your child has been involved in: _____

Does your child have difficulty interacting with you or others? Y / N _____

Are you aware of any food allergies or intolerances? Y / N _____

Vaccine history - please circle one: Full Schedule Revised Schedule None

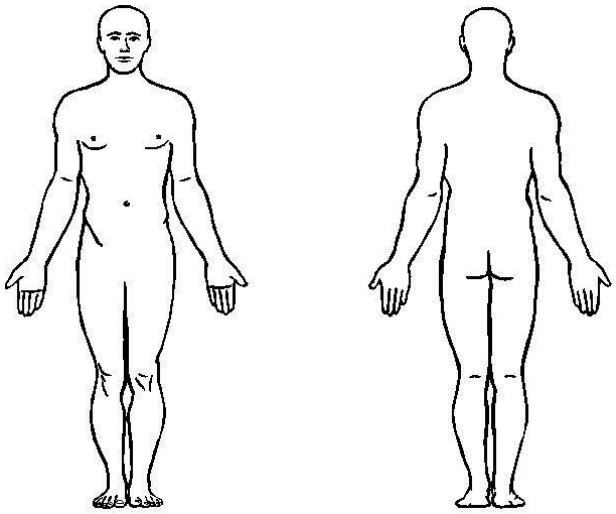
Please rate your child's personal stress: (Low) 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 (High)

Please rate your child's school stress: (Low) 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 (High)

"The moment you change your perception is the moment you rewrite the chemistry of your body."
(Bruce Lipton, PhD)
Chiropractic is the science of changing your brain's perception of its physical environment (your body)

MEDICATIONS YOUR CHILD TAKES	SUPPLEMENTS
Anxiety Depression Blood pressure Pain medication Insulin	Multi-vitamin Vitamin D3 Fish Oil
Muscle relaxers Migraine/headache Cholesterol ADD/ADHD	Probiotic Other:_____

PHYSICAL SYMPTOMS



Please circle the specific areas of the body where you are experiencing pain or other symptoms

"Adjusting the spine changes the way the prefrontal cortex of the brain is processing information… The prefrontal cortex is responsible for behavior, goal directed tasks, decision making, memory and attention, intelligence, pain and the processing of emotional response to it, autonomic function, motor control, and spatial awareness"

Heidi Haavik, DC, PhD

COMMON ASSOCIATED AUTONOMIC/NEUROLOGIC SYMPTOMS

❑ Anxiety	❑ Autism Spectrum	❑ Stomach Problems
❑ Depression	❑ Dizziness	❑ Bloating
❑ Irritability	❑ Poor Sleep	❑ Diarrhea
❑ Low Energy/fatigue	❑ Sinus Problems	❑ Constipation
❑ ADHD/ADD	❑ Allergies	❑ Menstrual Problems
❑ Difficulty Concentrating	❑ Asthma	❑ Reproductive Problems
❑ Anger/Moodiness	❑ Frequent Colds/Flu	❑ Other: _____
❑ OCD/ODD, etc.	❑ Excessive Worry	❑ Other_____

FACTORS AFFECTING HOW YOUR CHILD GROWS AND HEALS

Diet

(Target: meat and vegetables, nuts and seeds, some fruit, little starch, and no sugar)

(Poor) **1 ----- 2 ------ 3 ------ 4 ------ 5 ------ 6 ------ 7 ------ 8 ------ 9 ------ 10** (Excellent)

Exercise

(Target: 5 days per week, 30+ minutes each day)

(0 days per week) **1 ----- 2 ------ 3 ------ 4 ------ 5 ------ 6 ------ 7 ------ 8 ------ 9 ------ 10** (5 days 30 mins each)

Sleep

(Target: 8 hours per night)

(3 hrs/night) **1 ----- 2 ------ 3 ------ 4 ------ 5 ------ 6 ------ 7 ------ 8 ------ 9 ------ 10** (8+ hours nightly)

Stress

(Target: relatively low stress with excellent stress management)

(High stress) **1 ----- 2 ------ 3 ------ 4 ------ 5 ------ 6 ------ 7 ------ 8 ------ 9 ------ 10** (Not stressed)

Modern research supports more and more the theory that chiropractic adjustments profoundly influence both the body and the brain through structural rehabilitation of the spine and neurological stimulation through the neuro-sensory pathways. This holistic approach to health care allows the body to heal itself, rather than forcing the suppression of symptoms.

PATIENT HIPAA CONSENT

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment, or practice operations will be made only after obtaining your consent. You may request restrictions on your disclosures. You may inspect and receive copies of your records within 30 days with a request. You may request to view charges to your records. In the future, we may contact you for appointment reminders, announcements, and to inform you about our practice and its staff.

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information an and will be used to: conduct, plan, and direct my treatment and follow up with multiple health care providers who may be involved in that treatment directly or indirectly, obtain payment from third party payers, and conduct normal healthcare operations such as quality assessments and physician's certificates. I have read and understand your Notice of Privacy Practices. A more complete description can be requested. I also understand that I can request, in writing, that you restrict how my personal information is used and disclosed.

FINANCIAL POLICY

Our goal is to provide the highest quality of healthcare possible for our patients. In order to achieve this goal, we need your commitment as well. We urge our patients to follow the doctor's recommendations for care. Please keep your appointments as scheduled or call our office within 24 hours to make any changes. In order to attain the level of achievement we both desire, care plans must be followed. If you have any questions about our financial policies, please ask to speak to our financial officer. If you need to make special arrangements, please ask. We will never deny care to anyone based solely on ability to pay. We will do everything possible to meet your financial needs. By signing below,

- You authorize Timpview Chiropractic to release any information deemed appropriate concerning your physical condition to any insurance company, attorney, or adjuster in order to process any claim for reimbursement or charges incurred by you or your dependents.
- You authorize the direct payment to Timpview Chiropractic of any sum you now or hereafter owe by your attorney out of settlement of your case, and by any insurance company obligated to make payment to you or Timpview Chiropractic based in whole or in part upon the charges made for services received.
- You hereby appoint Timpview Chiropractic to endorse and cash checks, drafts, or money orders made payable to the undersigned or as co-payee with this clinic for payments due for services rendered on behalf of the undersigned by Timpview Chiropractic
- You acknowledge that Timpview Chiropractic is not a financial savings institution. Therefore any unused credit on your financial account is available for use indefinitely, but if your account becomes inactive for a period of 12 months or more, the unused credit will be ineligible for cash refund.
- You will provide current, accurate insurance information for yourself and your dependents when requested. While Timpview Chiropractic will do its best to confirm your eligibility and level of insurance coverage for care, you understand that it is ultimately your responsibility to know your own insurance benefits in relation to what your insurance covers. Should your insurance carrier determine that any of Timpview Chiropractic's services are ineligible for payment, you will be billed directly for those services.
- Advanced Beneficiary Notice of NON-Coverage (ABN): In the event that Timpview Chiropractic bills your insurance, they may not pay for items or services rendered by our office. Signing below signifies that you want these items and services, but understand that they will not be billed to your insurance company. Therefore, you are responsible for payment and cannot appeal to your insurance carrier as they were not submitted and/or billed to them. This notice gives our opinion, not an official Medicare or other insurance carrier's decision. If you have other questions, please ask our front desk. Signing below means you have received and understand this notice.

AUTHORIZATION FOR CARE

I hereby authorize doctors and staff at Timpview Chiropractic to evaluate and treat my condition as deemed appropriate. At Timpview Chiropractic, we do not diagnose or treat any disease or condition other than vertebral subluxation, and the doctor/clinic will not be held responsible for any pre-existing medical conditions. I certify that the above information is correct to the best of my knowledge. I will not hold any doctor of staff member of Timpview Chiropractic responsible for any errors or omissions that I may have made in the completion of this form. Chiropractic, as other types of health care, is associated with potential risks in the delivery of treatment. While chiropractic treatment is remarkably safe, certain risks, however slight, have been identified. These include, but are not limited to strain, sprain, instability, fracture, stroke, and bruising. Certain pre-existing conditions may increase your likelihood of negative side-effects, so please ask us if you have questions or concerns about those listed. Chiropractic is a system of health care delivery and therefore, as with any health care delivery system, we cannot promise a cure for any symptom, condition, or disease as a result of treatment in this office. An attempt to provide you with the very best care is our goal, and if the results are not acceptable, we will refer you to another provider who we feel can further assist you.

Patient Name (please print): _____

Parent/Guardian Signature: _____ Relationship to patient: _____

Date: _____