



PEDIATRIC INTAKE FORM

Date: _____

PERSONAL INFORMATION

Child's First Name: _____ M.I.: _____ Last Name: _____
Preferred Name: _____ Sex: M / F
Address: _____
City / State / Zip: _____
Birth Date: _____ Age: _____
of Siblings: _____ Sibling's Names/Ages: _____
Parent's Names: _____
Best Contact Phone: () _____ Alternate Phone: () _____
Parent's Email: _____
We love our patients! Who can we thank for your referral or how did you hear about our office? _____

REASON FOR SEEKING CARE

What is your reason for seeking care at B Well Family Chiropractic? _____
When did this begin? (if applicable) _____
Are there any major injuries and/or surgeries since birth? _____
What is this affecting that is MOST important in your child's life? (List all that apply) _____
Has your child seen a chiropractor before? YES / NO Date of last visit: _____
What is your level of commitment to your child's health? 1 2 3 4 5 6 7 8 9 10
Explain: _____
What health goals, if you child were to complete/accomplish, would have the greatest impact on his/her/your life? _____

HEALTH CONCERNS

- | | |
|---|--|
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Fatigue/Sleep Issues |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Asthma/Chronic Bronchitis |
| <input type="checkbox"/> Nausea/Vomiting | <input type="checkbox"/> Colic/Acid Reflux |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Back/Neck Pain/Stiffness |
| <input type="checkbox"/> Bedwetting | <input type="checkbox"/> Difficulty Gaining Weight |
| <input type="checkbox"/> Overweight | <input type="checkbox"/> Ear or Other Infections |
| <input type="checkbox"/> Frequent Sadness | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Learning Disorders |
| <input type="checkbox"/> Detachment/Distant | <input type="checkbox"/> Sinus Trouble/Allergies |
| <input type="checkbox"/> Irritability/Nervousness | <input type="checkbox"/> Autism/Asperger's |
| <input type="checkbox"/> Other _____ | |
| <input type="checkbox"/> Other _____ | |
| <input type="checkbox"/> Other _____ | |

Explain any boxes checked above:

Is there anything else regarding your child's current condition you feel the doctor should know? _____

MEDICATIONS

- | | |
|---|--|
| <input type="checkbox"/> Anxiety/Depression | <input type="checkbox"/> Migraine/Headache |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Acid Reflux |
| <input type="checkbox"/> Pain Narcotics | <input type="checkbox"/> ADD/ADHD |
| <input type="checkbox"/> Antibiotics | <input type="checkbox"/> Digestive |
| <input type="checkbox"/> Other _____ | |
| <input type="checkbox"/> Other _____ | |
| <input type="checkbox"/> Other _____ | |

Explain any boxes checked above: _____

DID YOU KNOW...

Each health concern relates to a specific area of the spine and nervous system? Please circle below or enter the information to the left.

- Sore Throat
- Stiff Neck
- Radiating Arm Pain
- Hand/Finger Numbness
- Asthma
- Allergies
- High Blood Pressure
- Heart Conditions



- Headaches
- Migraines
- Dizziness
- Sinus Problems
- Allergies
- Fatigue/Sleep Problems
- Head Colds
- Vision Problems
- Difficulty Concentrating
- Hearing Problems

- Congestion
- Difficulty Breathing
- Bronchitis
- Pneumonia
- Middle Back Pain
- Gallbladder Conditions
- Stomach Problems
- Ulcers
- Gastritis
- Kidney Problems
- Indigestion

- Constipation
- Colitis
- Diarrhea
- Gas Pain
- Irritable Bowel
- Bladder Problems
- Menstrual Problems
- Low Back Pain
- Pain/Numbness in Legs
- Reproductive Problems

VITAMINS/SUPPLEMENTS

- | | |
|--|---|
| <input type="checkbox"/> Multi-Vitamin | <input type="checkbox"/> Fish Oil/Omega 3 |
| <input type="checkbox"/> Vitamin D3 | <input type="checkbox"/> Probiotics |
| <input type="checkbox"/> Other _____ | |
| <input type="checkbox"/> Other _____ | |
| <input type="checkbox"/> Other _____ | |

Explain any boxes checked above: _____

Print Patient's Name: _____ Date: _____

PRENATAL HISTORY

Location of birth: Home / Birthing Center / Hospital / Other: _____

Did any of the following happen during delivery:

C-Section	Doctor pulled or twisted baby	Premature	Induced Labor
Anesthesia	Forceps/Vacuum	Special medical procedure/tests	

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

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

Did you experience any illness while pregnant? Yes / No If yes, explain: _____

Do you have any physical disabilities? Yes / No If yes, explain: _____

Birth weight: _____ Birth Length: _____ APGAR score: _____

Ultrasound used during pregnancy: Yes / No Number of times: _____

Did you breastfeed? Yes / No If yes, how long? _____

Did you formula feed the baby? Yes / No If yes, how long? _____

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

LIFESTYLE HABITS

Does your child exercise daily? Yes / No How much? _____

Does your child drink soda? Yes / No How much/often? _____

Does your child have a positive self-esteem or self-image? Yes / No

Does your child watch more than an hour of TV per day? Yes / No How much? _____

Does your child eat balanced meals? Yes / No

Does your child experience prolonged sadness? Yes / No Explain: _____

Does your child have difficulty sleeping? Yes / No Explain: _____

Does your child play video games? Yes / No How much? _____

CURRENT HEALTH STATUS

The National Safety Council reports approximately 50% of children fall head first from a high place during their first year of life (bed, changing table, stairs, etc.). Was this the case for your child? Yes / No Explain: _____

Has your child ever been hospitalized or had surgery? Yes / No Explain: _____

Does your child have difficulty interacting with others? Yes / No Explain: _____

Have you noticed that your child is nervous, twitches, shakes, or exhibits rocking behavior? Yes / No Explain: _____

Has your child been involved in high impact/contact sports (soccer, football, martial arts, cheerleading)? Yes / No
Please List: _____

Are you aware of any food allergies or intolerances? Yes / No Explain: _____

Has your child received all recommended vaccinations? Yes / No Explain: _____

Please rate stress levels on a scale of 1-10 (10 being highest)

School: 1 2 3 4 5 6 7 8 9 10 Personal: 1 2 3 4 5 6 7 8 9 10

CURRENT HEALTH STATUS

I, (Parent/Guardian) _____, give B Well Family Chiropractic permission to examine, x-ray (if necessary), and treat _____ . Minor date of birth: _____

Parent/Guardian Signature: _____ Date: _____

Print Patient's Name: _____ Date: _____

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such 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 used to attain it. This will prevent any confusion or disappointment.

Adjustment: 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 of the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, 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. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxation.

I have read and fully understand the above statements. All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis.

Signature	Relationship to Patient	Date
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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 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 need 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 has 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.

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

Signature	Relationship to Patient	Date
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X-RAY CONSENT This is to certify that Dr. VanKirk has my permission to perform an X-ray evaluation. 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. If female, date of last menstrual period: _____.

Signature	Relationship to Patient	Date
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INSURANCE 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. I have been notified by my physician 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.

Signature	Relationship to Patient	Date
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PERSONAL FINANCIAL RESPONSIBILITY I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Dr. VanKirk 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 Dr. VanKirk 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.

Signature	Relationship to Patient	Date
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