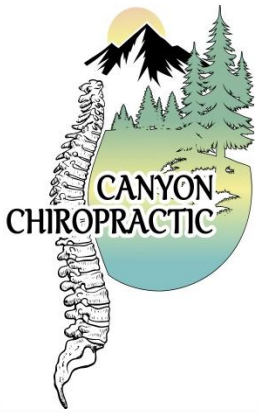


PEDIATRIC INTAKE FORM

Date:_____

PERSONAL INFORMATION

Child's First Name:_____ M.I.:_____ Last Name:_____

Preferred Name:_____ Social Security Number:_____

Address:_____

City/State/Zip:_____

Birth Date: _____ Age:_____ Sex: M F

# of Siblings:_____

Sibling(s) Names & Ages:_____

_____

Parents' Names: _____

Best Contact Phone: ( ) _____

Alternate Phone: ( ) _____

Email:_____

Who can we thank for referring you to Eklund Chiropractic?_____

REASON FOR SEEKING CARE

What is your reason for seeking care at Eklund Chiropractic?_____

_____

When did this begin? (If applicable):_____

Are there any major injuries and/or surgeries we should know about?_____

_____

What is this affecting that is MOST important in your child's life? (List all that apply): _____

_____

Has your child seen any other providers for this condition? (List all that apply): _____

_____

Has your child seen a chiropractor before? Yes No

How long ago?_____ Clinic/Doctor Name: _____

What is your reason for the change? (If applicable):_____

What is your level of commitment to your child's health? 1 2 3 4 5 6 7 8 9 10

Explain: _____

What health goal, if your child were to complete or accomplish it, would have the greatest impact on his/her life?

_____

_____

HEALTH CONCERNS

- ☐ Anxiety/Depression
- ☐ Constipation/Diarrhea
- ☐ Nausea/Vomiting
- ☐ Diabetes
- ☐ Bed Wetting
- ☐ Overweight
- ☐ Frequent Sickness
- ☐ ADD/ADHD
- ☐ Detachment/Distant
- ☐ Irritability/Nervous
- ☐ Fatigue/Sleep Issues
- ☐ Asthma/Chronic Bronchitis
- ☐ Colic/Acid Reflux
- ☐ Back/Neck Pain/Stiffness
- ☐ Difficulty Gaining Weight
- ☐ Ear or Other Infections
- ☐ Headaches
- ☐ Learning Disorders
- ☐ Sinus Troubles/Allergies
- ☐ Autism/Asperger's
- ☐ Other_____

Explain any boxes checked above or additional concerns:

_____

_____

_____

_____

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

_____

_____

MEDICATIONS

- ☐ Anxiety/Depression
- ☐ Asthma
- ☐ Pain Narcotics
- ☐ Antibiotics
- ☐ Migraine/Headache
- ☐ Acid Reflux
- ☐ ADD/ADHD
- ☐ Digestive
- ☐ Other_____
- ☐ Other_____
- ☐ Other_____

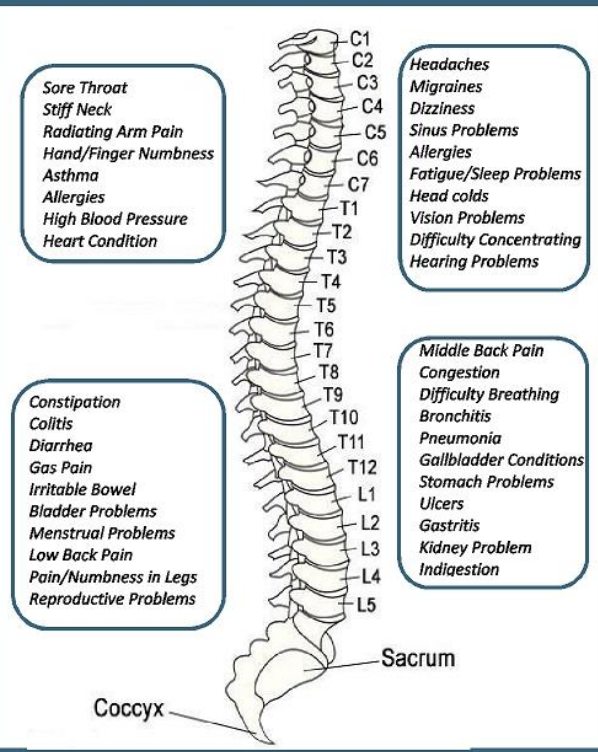
Explain any boxes checked above:_____

_____

_____

Please circle your child's health concern's below.

Every health concern relates to a specific area of the spine and nervous system.



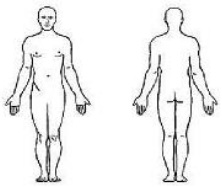
VITAMINS/SUPPLEMENTS

- ☐ Multi-Vitamin
- ☐ Vitamin D3
- ☐ Fish Oil/Omega-3
- ☐ Probiotics
- ☐ Other:_____
- ☐ Other:_____
- ☐ Other: _____

LOCATION & QUALITY OF PAIN

Neck & Upper Back

Neck L R
Upper Back L R
Thoracic L R



Quality
Aching Dull Sharp Burning
Constant Intermittent Throbbing
Cramping Tightness
Numbness Swelling Shooting
Radiating Headaches

Sensations
Burning Numbness
Pins & Needles Tingling
Throbbing

Severity
Normal lifestyle School
Sleeping Work Eating

Pain Scale
1 2 3 4 5 6 7 8 9 10
(Circle multiple numbers if pain ranges)

How long have symptoms been present?

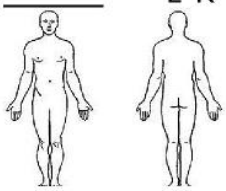
_____

Pain is Exacerbated by:
Driving Joint use Movement
Sitting Standing Bending Rest Twisting
Walking Physical Activity

(If it applies) Mechanism of Injury
Bending Jogging Lifting
Lifting and Turning,
Motor Vehicle Accident
(Driver, Passenger, Pedestrian)
Repetitive injury Running Sports Turning
Twisting Walking Working

Low Back &Other

Lower back L R
Hip L R
_____ L R
_____ L R



Quality
Aching Dull Sharp Burning
Constant Intermittent Throbbing
Cramping Tightness
Numbness Swelling Shooting
Radiating

Sensations
Burning Numbness
Pins & Needles Tingling
Throbbing

Severity
Normal lifestyle School
Sleeping Work Eating

Pain Scale
1 2 3 4 5 6 7 8 9 10
(Circle multiple numbers if pain ranges)

How long have symptoms been present?

_____

Pain is Exacerbated by:
Driving Joint use Movement
Sitting Standing Bending Rest Twisting
Walking Physical Activity

(If it applies) Mechanism of Injury
Bending Jogging Lifting
Lifting and Turning,
Motor Vehicle Accident
(Driver, Passenger, Pedestrian)
Repetitive injury Running Sports Turning
Twisting Walking Working

INFORMED CONSENT TO TREAT/ HIPPA

Dr. Alyssa Oltmanns, DC Revised 12/2024

You make the decisions regarding your health care. Our role is to provide you with information to aid you in making informed decisions. This is referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the associated benefits and risks, as well as the potential effect on your health should you choose not to receive care.

If indicated, diagnostic exams may be conducted. These exams will be performed carefully, but may cause discomfort.

Chiropractic care mainly involves the chiropractic adjustment; however there may be additional procedures or recommendations. To complete a chiropractic adjustment, the doctor uses their hands or assistive instruments to influence anatomical structures, such as vertebrae. Potential benefits of a chiropractic adjustment include restoring normal joint motion, reducing joint swelling, inflammation, and pain, and improving neurological function.

It is important to understand, as with all health care approaches, that results are not guaranteed and there is no promise of a cure. There exists some risks to care, including, but not limited to: muscle spasm, aggravating and/or temporarily increasing symptoms, lack of improvement of symptoms, burns/scarring from electrical stimulation and hot/cold therapies, fractures, disc injuries, strokes, dislocations, strains, and sprains. In regard to strokes, there is a rare, but serious condition known as an arterial dissection that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustments do not cause a dissection on a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection

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 can and will be used to: conduct, plan and direct my treatment and follow up with multiple healthcare 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 certificated. I have read and understand your Notice of Privacy Practices. A more completed description can be requested. I understand that I can request, in writing, that you restrict how my personal information is used and disclosed.

It is also important that you understand there are more treatment options available for your condition other than chiropractic procedures. These options may include: self-administered care, over-the-counter pain relievers, physical measures and rest, prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendations to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future conditions for which I seek chiropractic care from this office.

Name of Patient:_____ Date: _____

Signature of Patient:_____

Name Printed of Guardian/Parental and Relationship to Patient:_____

Guardian/Parental Signature:_____ Date: _____