Name:

EMBRACING LIFE CHIROPRACTIC

giving hope for a brighter tomorrow

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 Names & Ages:_____

Contact Phone: ( ) _____ Alternate Phone: ( ) _____

Parent's Email:_____

Who can we thank for referring you or how did you hear about Embracing Life? _____

_____

Reason for Seeking Care

What is your reason for seeking care at Embracing Life 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 life? (List all that apply)

Have you seen any other providers for this condition? (List all that apply)

Have you seen a chiropractor before? Yes No

Name:

How long ago? _____ Clinic/Doctor Name:_____

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

What is your level of commitment to yourself and your health? 1 2 3 4 5 6 7 8 9 10

Explain: _____

What health goal, if you were to complete or accomplish it, would have the greatest impact on your life? _____

_____

Health History

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

- ☐ Other _____
- ☐ Other _____
- ☐ Other _____

Explain any boxes checked above:

_____

_____

_____

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

_____

_____

_____

_____

_____

_____

Medications

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

- ☐ Allergies
- ☐ Other _____
- ☐ Other _____
- ☐ Other _____

Explain any boxes checked above:

_____

_____

_____

Vitamins & Supplements

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

☐ Explain any boxes checked above:

_____

_____

Name:

Prenatal History

Location of birth: Home Birthing Center Hospital Other: _____

Did any of the following happen during delivery:

☐ C-section delivery ☐ Doctor pulled or twisted baby ☐ Anesthesia ☐ Labor was induced
☐ Forceps/vacuum extraction ☐ Premature delivery ☐ Special medical procedures/tests

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

During pregnancy, did you experience any illness, complications and/or concerns? If yes, please explain:

Birth weight: _____ Birth length: _____ APGAR scores (if remembered): _____
Ultrasound used during pregnancy? Yes No Number of times: _____
Did /do you breastfeed the baby? Yes No If yes, how long: _____
Did/do 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?_____
Have a positive self-esteem or self-image? Yes No
Play video games or watch TV for more than one hour per day? Yes No How much? _____
Eat balanced meals? Yes No
Experience prolonged sadness? Yes No Explain:_____
Have difficulty sleeping? Yes No Explain: _____

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 any high impact/contact sports (soccer, football, martial arts, cheerleading, etc.)?
Yes No
Please list:_____

Are you aware of any food allergies or intolerance? Yes No

Name:

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

Permission to Treat a Minor

I, (Parent/Guardian) _____, give Embracing Life Chiropractic permission to examine, and treat _____.

Minor date of birth: _____

Parent/Guardian Signature: _____ Date: _____

Witness Signature: _____

HIPAA Consent Form

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to define 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 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 certificates. I have read and understand your Notice of Privacy Practices. I also understand that I can request in writing that you restrict how my personal information is used and disclosed.

Date: _____ Print Patient Name: _____

Signature: _____ Relationship to Patient: _____

Name:

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, your care plan must be followed.
- I authorize Embracing Life Chiropractic to release any information deemed appropriate concerning my physical condition to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred by me.
- I authorize direct payment to Embracing Life Chiropractic of any sum I now or hereafter owe by my attorney out of settlement of my case, and by any insurance company obligated to make payment to me or Embracing Life Chiropractic based in whole or in part upon the charges made for service received. I hereby appoint Embracing Life Chiropractic authority to endorse and cash checks, drafts, or money orders made payable to the undersigned or as a co-payee with this clinic or payments due for services rendered on behalf of the undersigned by Embracing Life Chiropractic.
- An itemized receipt will be provided upon request, although we cannot guarantee reimbursement by a third party carrier. This does not apply to PI, WC, or Medicare. HSA and FLEX spending accounts may be utilized.
- If you have any questions about our financial policies, please ask our staff. If you need to make special arrangements, please ask. We will do everything possible to meet your financial needs.

Consent to Chiropractic Services

I hereby authorize Dr. Nicole Mattson and staff, now and in the future, at Embracing Life Chiropractic, to treat my condition as deemed appropriate. At Embracing Life Chiropractic, we do not diagnosis 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 information obtained in the above health history is correct to the best of my knowledge. I will not hold the doctor or any staff members of Embracing Life Chiropractic responsible for any errors or omissions that I have made in the completion of this form. Chiropractic treatment, while remarkably safe, you still need to be informed of the potential risks related to your care to allow you to be fully informed before consenting to treatment. Please inquire if you have further questions. I do not expect the Doctor to be able to anticipate and explain all risks and complications, and wish to rely on the Doctor to exercise judgement during the course of any procedure which the Doctor feels at the time is in my best interest. 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. I have read, or have had read to me, the full above consent and have also had an opportunity to ask questions about its content and by signing below, I agree to the above terms and procedures. I intend this consent to cover any treatment for my present condition and for any future care provided by this clinic and/or employed staff.

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____