



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 Name: _____ Phone: () _____

Alternate Contact Name: _____ Phone: () _____

Email: _____ *(For updates on office hours, events, etc.)*

Who can we thank for referring you or how did you hear about Pinkus Family Chiropractic?

REASON FOR SEEKING CARE

What is your reason for seeking care at Pinkus Family 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 health goal, if your child were to complete or accomplish it, would have the greatest impact on his or her life? _____

HEALTH CONCERNS

- | | |
|--|---|
| <input type="checkbox"/> Anxiety/Depression | <input type="checkbox"/> Fatigue/Sleep Issues |
| <input type="checkbox"/> Constipation/Diarrhea | <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"/> Bed Wetting | <input type="checkbox"/> Difficulty Gaining Weight |
| <input type="checkbox"/> Overweight | <input type="checkbox"/> Ear or Other Infections |
| <input type="checkbox"/> Frequent Sickness | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Learning Disorders |
| <input type="checkbox"/> Detachment/Distant | <input type="checkbox"/> Sinus Troubles/Allergies |
| <input type="checkbox"/> Irritability/Nervous | <input type="checkbox"/> Autism/Asperger's/Sensory Issues |
| <input type="checkbox"/> Developmental Delay | |
| <input type="checkbox"/> Other _____ | |
| <input type="checkbox"/> Other _____ | |

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 _____ | |

VITAMINS/SUPPLEMENTS

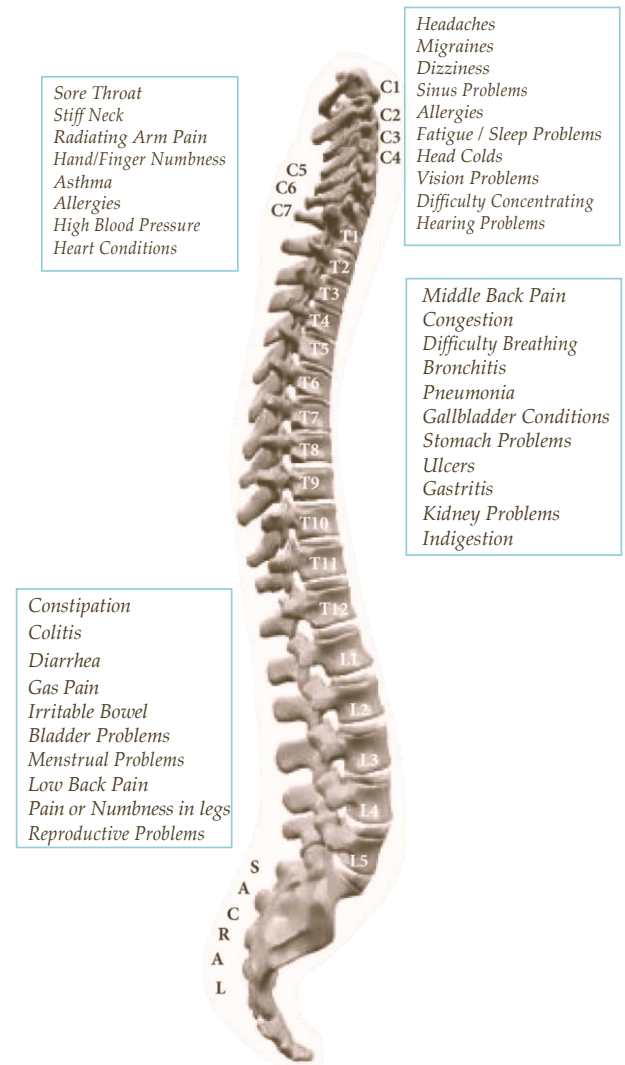
- | | |
|--|---|
| <input type="checkbox"/> Multi-Vitamin | <input type="checkbox"/> Fish Oil/Omega-3 |
| <input type="checkbox"/> Vitamin D3 | <input type="checkbox"/> Probiotics |
| <input type="checkbox"/> Other _____ | |
| <input type="checkbox"/> Other _____ | |
| <input type="checkbox"/> Other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

CIRCLE ACTIVITIES DURING WHICH YOU EXPERIENCE DIFFICULTY

Lying on Back	Lying on Side	Lying Flat on Stomach
Turning over in Bed	Getting in/out of Car	Dressing Self
Pushing	Pulling	Reaching
Kneeling	Stooping	Sitting
Bending Forward	Bending Backward	Walking
Standing	Coughing/Sneezing	
Other: _____		

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.



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 Explain: _____

Has your child received all recommended vaccinations? Yes No

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 Pinkus Family Chiropractic permission to examine, assess, and treat _____.

Minor date of birth: _____

Parent/Guardian Signature: _____ Date: _____

For Office Use Only

ID#: _____ Scan: _____ ROF: _____

CS: _____ E: _____ A: _____

Other _____

PATIENT HIPAA CONSENT FORM

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

** You may refuse to sign this acknowledgement. **

Release of Protected health information/HIPAA By signing this form, you are granting consent to Drs. Brenton and Kathleen Pinkus and/or Pinkus Family Chiropractic to use and disclose your protected health information for the purpose of treatment, payment and health care operations.

Our notice of Privacy Practices provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practices before you sign this consent, and we encourage you to read it in full. Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by contacting us at 802-362-7512. You have a right to request us to restrict how we use and disclose your protected health information. We are not required by law to grant your request. However, if we do grant your request, we are bound by our agreement. You have a right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your request. Acknowledgement of receipt of notice or privacy practices I have received a copy of the office's Notice of Privacy Practices.

I understand that 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 among the healthcare providers who may be directly and indirectly involved in providing my treatment.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and accreditation.

I, _____, have been offered to read and receive a copy of this office's Notice of Privacy Practices and give my consent for this office to use personal health information.

Please Print Name

Signature

Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign;
- Communication barriers prohibited obtaining the acknowledgement,
- An emergency situation prevented us from obtaining acknowledgement, Other (Please Specify) _____

AUTHORIZATION FOR CARE

I hereby authorize the doctors and staff at Pinkus Family Chiropractic to treat my condition as deemed appropriate. At Pinkus Family Chiropractic, we do not diagnose or treat any disease or condition other than vertebral subluxation and the doctors/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 the doctors or any staff member of Pinkus Family Chiropractic responsible for any errors or omissions that I may have made in the completion of this form. Chiropractic, as well as all other types of health care is associated with potential risks in the delivery of treatment. While chiropractic treatment is remarkably safe, you need to be informed about 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. 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.

Date: _____ Signature: _____

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 doctors' 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 must be followed.
- I authorize Pinkus Family 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 charges incurred by me.
- If using insurance which may include benefits for Chiropractic Care, I understand that my insurance policy may have a co-payment or deductible and I will be responsible for those charges and any services denied or not covered by my insurance company at each visit. I also realize my care may be subject to pre-authorization by the insurance company, and I accept any responsibility for charges not approved. The insurance company will review any/all documentation submitted by Pinkus Family Chiropractic for their assessment of medical necessity and base their approval/denial upon this documentation. I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account for professional services rendered.
- Your health insurance does not pay for everything, even some care that you or your health care provider have good reason to think you need. We know that some health insurance policies will not pay for items and services such as your initial visit and any chiropractic care deemed maintenance or wellness care by your carrier as well as other items such as massage therapy, examinations and taping. Signing below signifies that you want these items and services but understand that some of these services will not be billed to your insurance company. Therefore, you are responsible for payment and cannot appeal to your insurance carrier as services were not submitted and/or billed to them.
- I authorize the direct payment to Pinkus Family 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 Pinkus Family Chiropractic based in whole or in part upon the charges made for services received. I hereby appoint Pinkus Family Chiropractic authority to endorse and cash checks, drafts, or money orders made payable to the undersigned or as co-payee with this clinic or payments due for services rendered on behalf of the undersigned by
- I understand there are discounted fees, family plans and pre-paid visit discounts available to patients who do not have insurance or choose not to use insurance and will be furnished with these options at my first visit.
- If you have other questions, please ask our staff. Signing below means that you have received and understand this notice

Date: _____ Signature: (Patient/Parent/Guardian) _____

Patient Authorization for Chiropractic Care in an “Open Adjusting” Environment.

It is the practice of this office to provide chiropractic care in an “open adjusting” environment. Patients are within sight of one another and some ongoing routine details of care are discussed within earshot of other patients and staff. This environment is used for ongoing care and is not the environment used for taking patient histories, performing examinations or presenting reports of findings. These procedures are completed in a private, confidential setting.

We are requesting this authorization of you due to various interpretations under federal law with respect to what is known as an “incidental disclosures” of health information. It is our view that the kinds of matters related in an “open adjusting” environment are incidental matters. In the event you or someone else would not agree with us we are providing this disclosure.

The use of this format is intended to make your experience with our office more efficient and productive as well as to enhance your access to quality health care and health information. If you choose not to be adjusted in an “open adjusting” environment other arrangements will be made for you. Your decision will have no adverse effects on your care from Dr. Katie and Dr. Brenton or your relationship with our staff.

Your signature indicates your authorization of this activity.

Signature (patient/parent/guardian)

Date

This authorization may be revoked by you at any time. Revocation may be accomplished by advising us in writing of your desire to withdraw your authorization. Please allow a reasonable processing time for the change in our procedures to be completed.

Authorization to Leave Messages with Household Members/Answering Machine

From time to time it is necessary for representatives of Pinkus Family Chiropractic, to leave messages for patients. The purposes of these messages is to remind patients that they have an appointment, to notify the patient that the doctor would like to discuss results, or to ask a patient to call Pinkus Family Chiropractic, regarding an issue or concern. At no time will a representative of Pinkus Family Chiropractic discuss your medical circumstances or condition without your consent. The purpose of this consent is to leave messages with members of your household or on your answering machine. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

Patient Name: _____

Patient Signature: _____ **Date:** _____