PERRY FAMILY CHIROPRACTIC, LLC

PEDIATRIC INTAKE FORM

PERSONAL INFORMATION

Name:	Date:		
Address			
City, State	ZIP code:		
Home Phone:		Cell Phone:	
Date of Birth:		Gender: ☐Male ☐Female	
Age:	Height:	Weight:	Hand: ☐Right ☐Left
Who referred you to our office? :			
Childs Primary Health Care Provider:			

EMERGENCY CONTACT INFORMATION

Mother's name:	
Home Phone:	Cell Phone:
Father's name:	
Home Phone:	Cell Phone:
Other/Legal guardian:	Relationship:
Home Phone:	Cell Phone:

INSURANCE INFORMATION

Co. Name:	
Address:	
Phone number:	
Insured's ID number:	
Group number (Plan, Local, or Policy #):	
Insured's Name:	
Relation:	Date of Birth:
Insured's Employer:	

PRIMARY CONCERN

Please select any of the applicable reasons for you pursuing chiropractic care for your child:

☐ He/She is continuing care from another chiropractor.
☐ I recently had my spine checked and see the value in a subluxation check-up
☐ I am concerned about his/her health and am looking for answers.
☐ He/She has a specific condition that concerns me.

- Please explain:_____

☐ Other:

Date of onset/duration:

Is this visit the result of an auto injury? ☐ Yes ☐ No

- If yes when did the accident occur:

Has your child seen another doctor for this concern? ☐ Yes ☐No

- Doctors name:

Has your child been to a chiropractor before? ☐ Yes ☐No

- Doctors name:

Has your child been treated by a physician for any condition in the previous 12 months? ☐ Yes ☐No

- If yes please explain:

MEDICATIONS (Please list medication names where possible)

☐ Antibiotics Number of doses: Past 6 months:_____, Lifetime _____	☐ Antidepressants Number of doses: Past 6 months:_____, Lifetime_____ _____	☐ Bronchodilators (Asthma) Number of doses: Past 6 months:_____, Lifetime _____
☐ Birth Control	☐ Muscle Relaxants	☐ Cold medication

☐ Anti-inflammatories / Pain killers
☐ Aspirin / ASA (acetylsalicylic acid)
☐ Advil / Ibuprofen
☐ Tylenol / Anacin / Acetaminophen
☐ Corticosteroids (prednisone, asthma drugs,etc)
☐ Robaxin / Robaxacel / Robax Platinum, etc

☐ I am currently not taking any medication

Has your child taken any medication for an extended period of time in the past? ☐ Yes ☐ No
If Yes please list:

Does your child currently take any herbal or vitamin supplementations? ☐Yes ☐ No
If yes please list:

☐ Allergies (please list):

VACCINATION HISTORY

Has your child been immunized? ☐ Yes ☐ No

Reason for vaccination: ☐ Informed decision ☐ Recommended ☐ I didn't know I had a choice

Did your child have a negative reaction to the vaccinations? ☐ Yes ☐ No
If yes were they reported? ☐ Yes ☐ No

GENERAL HEALTH HISTORY

Has there been a recent change in your child's energy level? ☐ Yes ☐ No

How would you describe your child's health? ☐ Robust ☐ Poor ☐ Good ☐ Sickly ☐ Average

At what age was your child able to :
Hold head up: Sit up: Cross Crawl: Walk alone:

Have you ever been told your child has unusual skeletal changes (e.g. Scoliosis, unusual vertebrae, short legs etc.)? ☐ Yes ☐ No
If yes please describe:

Has your child had any surgeries? ☐ Yes ☐ No

CONTINUE TO NEXT PAGE ➔

GENERAL HEALTH HISTORY CONT…

Please check the conditions your child has been treated for:

☐ Ear Infection	☐ Growing Pains	☐ Recurring Fevers
☐ Asthma	☐ Back Pains	☐ Neck Pains
☐ Colic	☐ Seizures	☐ Bed Wetting
☐ Allergies	☐ Sinus Troubles	☐ Temper Tantrums
☐ Headaches	☐ Eczema/Skin Problems	☐ Bronchitis/Upper Respiratory Infections
☐ Scoliosis	☐ Constipation / Diarrhea	☐ Attention Problems – ADD/ADHD
☐ Digestive Problems	☐ Chronic Colds	☐ Other (specify):

Family Health History

Please check the conditions that any blood relatives have had

☐ Alcoholism	☐ Cancer	☐ High Blood Pressure
☐Anemia	☐ Diabetes	☐ High Cholesterol
☐ Arteriosclerosis	☐ Emphysema	☐ Multiple sclerosis
☐ Arthritis	☐ Epilepsy	☐ Osteoporosis
☐ Asthma	☐ Glaucoma	☐ Stroke
☐ Bleed Easily	☐ Heart disease	☐ Thyroid Disease

Baby / Toddler (0-4)

Have any of the following occurred?

☐ Fall from a changing table	☐ Fall out of a crib	☐ Fall off of playground equipment
☐ Tumble down stairs	☐ Play in a Johnny Jumper	☐ Involvement in a car accident

BIRTHING HISTORY

Medications during pregnancy? ☐ Yes ☐ No

Medications during labor / delivery? ☐ Yes ☐ No

Ultrasounds during pregnancy? ☐ Yes ☐ No If yes, how many?

Were you induced? ☐ Yes ☐ No

Was you delivery: ☐ Vaginal ☐ C-section

Were any of the following used during delivery?
☐ Forceps ☐ Vacuum ☐ Extraction ☐ Other:

Was your child at the time during your pregnancy in an intra-uterine constraining position:
☐ Breech ☐ Transverse Lie (side lying) ☐ Face/Brow Presentation

Any complications during delivery? ☐ Yes ☐ No
If yes please explain:

Location of Birth:
☐ Home ☐ Hospital ☐ Birthing Center

Birth Weight: Length:

Formula Fed: ☐ Yes ☐ No, If yes how many months?

Breast Fed: ☐ Yes ☐ No, If yes how many months?

Introduced to solid foods at how many months?

Introduced to cow's milk at how many months?

CONTINUE TO NEXT PAGE ➔

- We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between doctor and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services deeded during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.
-

Signature _____ Date ___/___/___

☐Parent ☐Guardian

PERRY FAMILY CHIROPRACTIC, LLC

Patient Non-Discrimination Notices

It is the policy of Perry Family Chiropractic not to engage in discrimination against, or harassment of, any person employed or seeking employment or patient care with Perry Family Chiropractic on the basis of race, color, national origin, religion, sex, sexual orientation, gender identity, pregnancy, physical, mental or other disability, medical condition, ancestry, marital status, age, sexual orientation, citizenship, or status as a veteran.

PERRY FAMILY CHIROPRACTIC, LLC

NOTICE OF PRIVACY PRACTICES

Dear patient:

This is not meant to alarm you! quite the opposite! It is our desire to communicate to you that we are taking the new Federal (HIPAA -Health Insurance Portability and Accountability Act) laws written to protect the confidentiality of your health information seriously. We do not ever want you to delay treatment because you are afraid your personal health history might be unnecessarily made available to others outside of our office.

The most significant variable that has· motivated the Federal government to legally enforce the importance of the privacy of health information is the rapid evolution of computer technology and its use in healthcare. The government has appropriately sought to standardize and protect the privacy of the electronic exchange of your health information. This has challenged us to review not only how your health information is used within our computers but also with the Internet, phone, faxes, copy machines, and charts. We believe this has been an important exercise for us because it has disciplined us to put in writing the policies and procedures we use to ensure the protection of your health information everywhere it is used.

We want you to know about these policies and procedures, which we developed to make sure your health information, will not be shared with anyone who does not require it. Our office is subject to State and Federal law regarding the confidentiality of your health information and in keeping with these laws we want you to understand our procedures and your rights as our valuable patient.

We will use and communicate your HEALTH INFORMATION only for the purposes of providing and conducting health care operations

How your HEALTH INFORMATION may be used

To Provide Treatment

We will use your HEATH INFORMATION within our office to provide you with the best health care possible. This may include administrative and clinical office procedures designed to optimize scheduling and coordination of care between physician and business office staff. In addition, we may share your health information with referring physicians, clinical and pathology laboratories, pharmacies or other health care personnel providing you treatment.

To Obtain Payment

We may include your health information with an invoice used to collect payment for treatment you receive in our office. We may do this with insurance forms filed for you in the mail or sent electronically. We will be sure to only work with companies with a similar commitment to the security of your health Information.

To Conduct Health Care Operations

Your health information may be used during performance evaluations of our staff. Some of our best teaching opportunities use clinical situations experienced by patients receiving care at our office. As a result, health information may be included in the training programs for students, interns, associates, and business and clinical employees. It is also possible, that health information will be disclosed during audits by insurance companies or government appointed agencies as part of their quality assurance and compliance reviews. Your health information may be reviewed during the routine processes of certification, licensing or credentialing activities.

In Patient Reminders

Because we believe regular care is very important to your general health, we will remind you of a scheduled appointment or that it is time for you to contact us and make an appointment.

Additionally, we may contact you to follow up on your care and inform you of treatment options or services that may be of interest to you or your family.

These communications are an important part of our philosophy of partnering with our patients to be sure they receive the best preventive and curative care modern medicine can provide. They may include postcards, folding postcards, letters, telephone reminders or electronic reminders such as

Documentation of Health Information
You have the right to ask us for a description of how and where your health information was used by our office for any reason than for treatment, payment or health care operations. Our documentation procedures will enable us to provide information on health information usage from April 13. 2003 and forward. Please let us know in writing the time period for which you are interested. Thank you limiting your request to no more than six years at a time. We may need to charge you a reasonable fee for your request.
Breach Notification: You will be notified of any breach of unsecured Patient Health Information.

PRIVACY NOTICE WRITTEN ACKNOWLEDGEMENT

I have received the Perry Family Chiropractic Notice of Privacy Practices.

_____ _____

Signature of Patient, Parent, or Legal Guardian Date

_____

Relationship to Patient

_____

Witness