

PEDIATRIC INTAKE FORM

PERSONAL INFORM	IATION					
Name:		Date:				
Address						
City, State		ZIP code:				
Home Phone:			Cell Phone:			
Date of Birth:			Gender: □Male	□Fe	nale	
Age:	Height:		Weight:		Hand: □Right □Left	
Who referred you to our						
Childs Primary Health C						
EMERGENCY CONT	ACT INFORMA	TION				
Mother's name:						
Home Phone:		Cell Phone:				
Father's name:						
Home Phone:		Cell Phone:				
Other/Legal guardian:		Relationship:				
Home Phone:		Cell Phone:				
INSURANCE INFOR	MATION					
Co. Name:						
Address:						
Phone number:						
Insured's ID number:						
Group number (Plan, Lo	cal, or Policy #):					
Insured's Name:						
Relation:	Date of	Birth:				
Insured's Employer:						

PRIMARY CONCERN		
Please select any of the applicable reaso	ns for you pursuing chiropractic care for	your child:
☐ He/She is continuing care from anoth	er chiropractor.	
☐ I recently had my spine checked and	-	
☐ I am concerned about his/her health a	-	
☐ He/She has a specific condition that	_	
Please explain:		
☐ Other:		
Date of onset/duration:		
Is this visit the result of an auto injury?	□ Yes □ No	
• If yes when did the accident occu	ır:	
Has your child seen another doctor for the	nis concern? Yes No	
Doctors name:		
Has your child been to a chiropractor be	fore? Yes No	
• Doctors name:		
Has your child been treated by a physici	an for any condition in the previous 12 r	nonths? ☐ Yes ☐ No
If yes please explain:		
MEDICATIONS (Please list medication	names where possible)	
☐ Antibiotics	☐ Antidepressants	☐ Bronchodilators (Asthma)
Number of doses:	Number of doses:	Number of doses:
Past 6 months:, Lifetime	Past 6 months:, Lifetime	Past 6 months:, Lifetime
☐ Birth Control	☐ Muscle Relaxants	☐ Cold medication
☐ Anti-inflammatories / Pain killers	•	nacin / Acetaminophen
☐ Aspirin / ASA (acetyls	-	oids (prednisone, asthma drugs,etc)
☐ Advil / Ibuprofen		obaxacel / Robax Platinum, etc
☐ I am currently not taking any medica	tion	
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 herba	al or vitamin supplementations? $\square Yes \square$	∃ No
If yes please list:		
☐ Allergies (please list):		
VACCINATION HISTORY		
Has your child been immunized? ☐ Ye		
Reason for vaccination: Informed de		ow I had a choice
Did your child have a negative reaction		
If yes were they reported? \square Yes \square N	0	
GENERAL HEALTH HISTORY		
Has there been a recent change in your o	hild's energy level? Yes No	
How would you describe your child's he	ealth? 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 a If yes please describe:	unusual skeletal changes (e.g. Scoliosis, unus	ual vertebrae, short legs etc.)? Yes No
Has your child had any surgeries?	es □ No	
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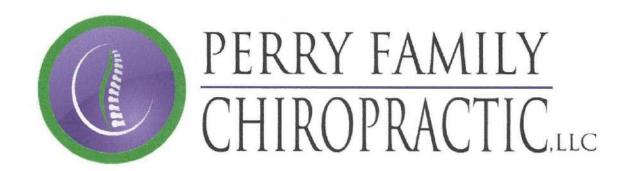
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GENERAL HEALTH HISTORY CO	NT	
Please check the conditions your child		
☐ Ear Infection	☐ Growing Pains	☐ Recurring Fevers
☐ Asthma	☐ Back Pains	☐ Neck Pains
□ Colic	☐ Seizures	☐ Bed Wetting
☐ Allergies	☐ Sinus Troubles	☐ Temper Tantrums
☐ Headaches	☐ Eczema/Skin Problems	☐ Bronchitis/Upper Respiratory Infections
☐ Scoliosis	☐ Constipation / Diarrhea	☐ Attention Problems – ADD/ADHD
☐ Digestive Problems	☐ Chronic Colds	☐ Other (specify):
Family Health History		— •• (»p••••)/
Please check the conditions that any b	olood 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)	I Tour disease	I Thyroid Discuse
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		☐ Involvement in a car accident
Medications during pregnancy? ☐ Yes	□ No	
Medications during labor / delivery? □		
Ultrasounds during pregnancy? Yes		
orange during pregnancy.	i yes, now many.	
Were you induced? ☐ Yes ☐ No		
W 11		
Was you delivery: ☐ Vaginal ☐ C	-section	
Were any of the following used during delivery?		
Forceps □ Vacuum □	•	
□ Porceps □ Vacuum □	Extraction Other.	
Was your child at the time during your page	regnancy in an intra-uterine constraining p	osition:
☐ Breech ☐ Transverse Lie (sid		
_	_	
Any complications during delivery? \square	Yes □ No	
If yes please explain:		
Y (75) 4		
Location of Birth:	~	
☐ Home ☐ Hospital ☐ Bir	thing 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 m	onths?	
Introduced to cover milk at how many m	outles?	

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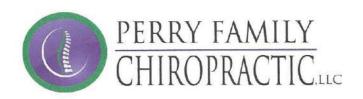
- We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between doctor and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with 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	



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.



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

<u>Documentation of Health Information</u>
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	of Privacy Practices.	
Signature of Patient, Parent, or Legal Guardian	Date	
Relationship to Patient		
Witness		