Dr. Stuart Johnson

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PEDIATRIC INTAKE AND HISTORY

Date: _____ Social Security # _____

Name: _____ Birth Date: _____ Age: _____

Mailing Address _____ City_____ State ____ Zip_____

Email Address _____ Home Phone: _____

Cell Phone: _____ Work Phone: _____

Gender: M / F

Parent's Name: _____ How Many Children Do You Have? _____

Referred By: Website__ Google __ Other __ Family/Friend/Doctor_____

Circle Appropriate Coverage: Self-Pay Insurance Medicaid/Title19

Insured Name (If not patient) _____ Insured Birth Date: _____

REASON FOR TODAY'S VISIT:_____

Is this condition: Wellness Checkup New Injury Other:_____

When Did This Condition/Accident Occur: ____/____/____ Where: _____

Type of Symptom If Any:_____
_____

Does Symptom Radiate/Travel in to Other Parts of Body: Y N Where:_____

Does Your Condition Interfere With: Sleep Daily Activity Nursing Crawling

Sports Focusing Playing School

Recent Health Issues/Complications: _____

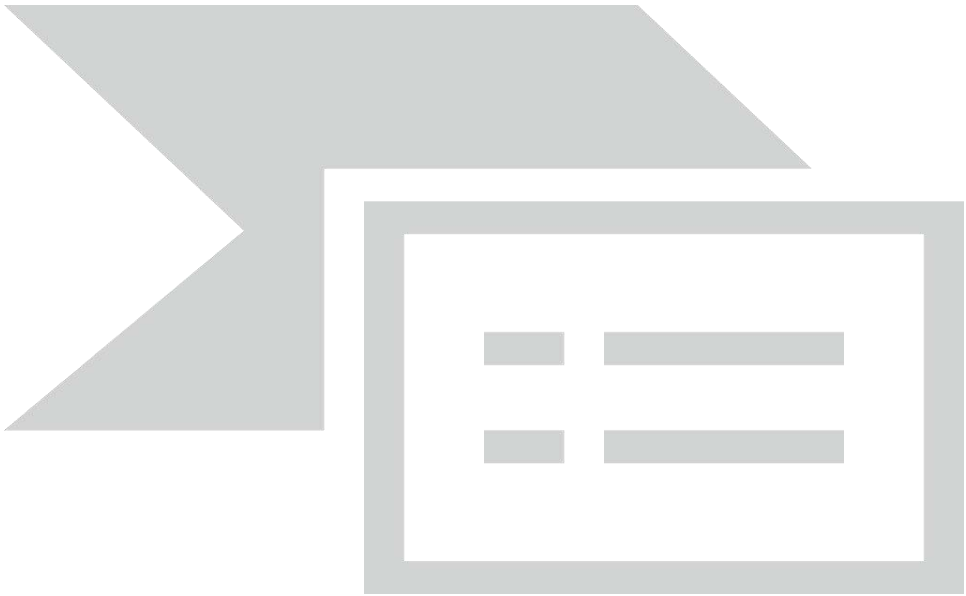
Birth History: Hospital Birth Center Pre-Eclampsia Pre-Term Cesarean

Nausea/Vomiting Pre-Term Problems during labor/delivery?_____

Antibiotics Congenital Anomalies Failure to Thrive Jaundice

Respiratory Distress Extended Hospitalization Other_____

Circle Areas of Health Concerns:



Height: _____

Weight: _____

Check any of the boxes that apply to you, CURRENT or PAST

□ Earache/Infections
□ Broken Bones
□ Stiff Neck
□ Torticollis
□ Sore Throat/Tonsillitis
□ Allergies
□ Difficulty Breathing
□ Asthma
□ Constipation
□ Diarrhea
□ Dizziness
□ Muscle Twitching
□ Joint Stiffness
□ Joint Pain
□ Back Aches
□ Tension Headache
□ Migraine
□ Neck Pain
□ Scoliosis
□ Hypertension
□ Depression
□ Anemia
□ Diabetes
□ Muscle Pain
□ Muscle Weakness
□ Muscle Cramps
□ Leg Problems
□ Facial Paralysis
□ Difficulty with Speech
□ Urinary Trouble
□ Colic/Fussiness
□ Heart Murmur
□ Heart Palpitations
□ Stroke
□ Anemia
□ Seizures
□ Vertigo
□ Dizziness
□ Diabetes
□ Juvenile Rheumatoid Arthritis
□ Uncoordinated
□ Abdominal Pain
□ Behavioral Problems
□ Bladder Trouble
□ Numbness
□ Tingling
□ Paralysis
□ Poor Appetite
□ ADHD/ADD
□ Anxiety
□ Autoimmune Dx

Any other concerns? _____

Please READ AND INITIAL the following:

Acknowledgement of Receipt of Notice of Privacy Practices: I have read/acknowledged the Notice of Privacy Practices for Protected Health Information. Notice of Privacy Practices is available at the front desk upon request.

Initials _____

Payment Policy: I acknowledge I am financially responsible for all charges incurred at Sturgis Chiropractic, P.C. It is the policy of this office that payment be made at the time of service for all services rendered. A copy of this policy is available at the front desk upon request.

Initials _____

Insurance Assignment: I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive. I understand that medical insurance rarely covers pediatric chiropractic services.

Initials _____

Signature of Patient or Parent/Guardian _____ Date _____

INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of procedures, including chiropractic adjustments, examinations, various modes of physiotherapy, diagnostic x-rays, and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by the Sturgis Chiropractic and /or other licensed providers and support staff who now or in the future treat me while employed by, working or associated with or serving as back-up providers, including those working at the clinic or office.

I will discuss with the Sturgis Chiropractic provider and/or with other office or clinic personnel the nature and purpose of the procedures, if I choose to do so.

I understand, as is with all healthcare treatments, results are not guaranteed and there is no promise to cure. I further understand and I am informed that, as is with all healthcare treatments, there are some risks to treatment, including, but not limited to, muscle spasms for short periods of time, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, fractures, disc injuries, strokes, dislocation and sprains. I do not expect the Sturgis Chiropractic provider to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I further understand that treatment is designed to improve health. I can also alleviate certain symptoms through a conservative approach with hopes to avoid more invasive procedures. However, like all other health modalities, results are not guaranteed and there is no promise to cure. Accordingly, I understand that all payment(s) for treatment(s) are final and no refunds will be issued.

I further understand that there are treatment options available for my condition, these treatment options include, but not limited to self-administered, over the counter analgesics, bracing, rest or medical care. I understand I have the right to a second opinion and secure other opinions if I have concerns as to the nature of my symptoms and treatment options.

I have read, or have had read to me, the above consent. I will ask the doctor questions about its consent if I have any, and by signing below I agree to the above-named procedures. I intent this consent to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Name of Patient: _____

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

Guardian/Parental Signature: _____

Date: _____