PEDIATRIC INTAKE & HISTORY

PATIENT INFORMATION

Patient Name _____
Address _____
City _____ State _____
Home Phone _____
Cell Phone _____
Email _____
Sex ❑ M ❑ F Age _____ Birthday _____

IN CASE OF EMERGENCY, CONTACT

Name _____
Relationship _____
Contact Number _____

Mother's Name _____
Mother's Occupation _____
Mother's Phone _____
Mother's Email _____

Father's Name _____
Father's Occupation _____
Father's Phone _____
Father's Email _____

Who may we thank for referring you?

_____

HOW CAN WE HELP YOUR CHILD?

❑ Wellness Checkup ❑ Other: _____

If your child is already experiencing a symptom, please describe it:

Has your child been treated on an emergency basis? ❑ Yes ❑ No

Please describe: _____

PREGNANCY HISTORY

Did you experience any complications during your pregnancy? (check all that apply)

❑ Back/Other Pain ❑ Gestational Diabetes ❑ Pre/Eclampsia ❑ Strep B ❑ Nauseau/Vomitting
❑ Pre-Term ❑ Fatigue ❑ Swelling ❑ Other (please describe) _____

BIRTH HISTORY

Type of birth (check all that apply):

❑ Hospital ❑ Birth Center ❑ Home ❑ Normal / Vaginal ❑ Breech
❑ Cesarean ❑ Scheduled/Induced ❑ Epidural

Problems during labor / delivery? _____

❑ Antibiotics ❑ Congenital Anomalies ❑ Failure to Thrive ❑ Jaundice ❑ Meconium
❑ Respiratory Distress ❑ Extended Hospitalization ❑ Other _____

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4358 Gibsonia Rd., Ste. G, Gibsonia, PA 15044 724-444-1960 info@backtolifechiro.com

GROWTH & DEVELOPMENT

Infant feeding: ❑ Breast ❑ Bottle ❑ Formula

Number of hours of sleep each night: _____ Quality of sleep: _____

At what age did the child:

Respond to sound: _____ Crawl: _____ Hold head up: _____

Stand: _____ Sit unsupported: _____ Walk unsupported: _____

CHILDHOOD DISEASES, ILLNESSES & VACCINATIONS

Has your child had (check all that apply)?:

❑ Chicken Pox ❑ Measles ❑ Rubeola

❑ Mumps ❑ Rubella ❑ Pertussis/Whooping Cough

Has your child ever suffered from (check all that apply)?:

❑ Allergies
❑ Anemia
❑ Arm Problems
❑ Asthma
❑ Back Aches
❑ Bed Wetting
❑ Behavioral Problems
❑ Broken Bones
❑ Chronic Ear Aches
❑ Colds/Flu
❑ Colic
❑ Convulsions/Seizures
❑ Delayed Speech
❑ Diabetes
❑ Digestive Issues (constipation/diarrhea)
❑ Dizziness
❑ Fainting
❑ Headaches
❑ Heart Trouble
❑ Hyperactivity
❑ Hypertension
❑ Jeuvenile Rheumatroid Arthritis
❑ Joint Problems
❑ Leg Problems
❑ Neck Problems
❑ Neuritis
❑ Orthopedic Problems
❑ Paralysis
❑ Poor Appetite
❑ Ruptures/Hernias
❑ Sinus Trouble
❑ Tuberculosis
❑ Walking Problems

Have you vaccinated your child?

❑ No ❑ Yes ❑ As scheduled ❑ Delayed Schedule

ALLERGIES, MEDICATIONS, SURGERIES & FAMILY HISTORY

ALLERGIES (list)

_____

_____

MEDICATIONS (list)

_____

_____

SURGERIES (list)

_____

_____

FAMILY HISTORY (list)

_____

_____

SIBLINGS

How many children do you have? _____

Children's' Ages: _____

Childrens' health concerns: _____

_____

Number of pregnancies: _____

Are you currently pregnant? ❑ No ❑ Yes, I'm due: _____

Health concerns regarding this pregnancy? _____

_____

DO YOU HAVE HEALTH INSURANCE?

❑ Yes, ❑ No

If yes, please present your insurance card.

Authorization for Care of Minor

I hereby authorize this clinic and its doctor(s) to administer care as they so deem necessary to my son/daughter/ward.

Signed: _____ Witnessed: _____ Date: _____

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Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an arterial dissection that involves an abnormal change in the wall of an artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. This occurs in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately a percentage of these patients will experience a stroke. As chiropractic can involve manually and/or mechanically adjusting the cervical spine, it has been reported that chiropractic care may be a risk for developing this type of stroke. The association with stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments.

In the event that x-rays are utilized as a diagnostic tool, it is important to understand that there are certain risks associated with exposure to ionizing radition, including potential damage to senstive organs. According to the rating system developed by the National Institutes of Health, the exposure risk level from the most commonly utilized studies in our office is considered "minimal". Exposure from a full spine x-ray is roughly equivalent to 167 days of exposure to normal, daily background radiation. (doseinfo-radar.com)

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name: _____ Signature: _____ Date: _____

Parent or Guardian: _____ Signature: _____ Date: _____

Witness Name: _____ Signature: _____ Date: _____

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OFFICE POLICY

Welcome to Our Office
We believe that a clear definition of our office and financial policies will allow us to concentrate on the primary goal of restoring or maintaining your health. If we do not believe your condition will respond to chiropractic care, we will not accept you as a patient but will refer you to another health care provider, if appropriate. Our practice will strive to provide you with the finest quality chiropractic care. If you have any questions, please do not hesitate to ask. We welcome referrals and look forward to establishing a satisfactory doctor-patient relationship.

Payment Options
You may choose to pay by cash, check, credit or by debit on the day that the treatment is rendered. Any other payment options will be discussed during your individual financial consultation.

Insurance
Insurance is a contract between you and your insurance company. We will provide you with the service of billing your insurance company for you. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. You agree to pay any portion of the charges not covered by your insurance.

Verification of Benefits
We may assist you, at our discretion, in verifying your insurance coverage in an effort to verify exactly what chiropractic coverage is available on your policy. You as the policy holder are primarily responsible to verify benefits. We cannot guarantee payment of the benefits and subsequently you may be responsible for any coinsurance, deductibles, or fees for non-covered services that may result.

Required Payments
Any co-payment, deductibles or coinsurance, fees for non-covered services, or outstanding balances must be paid at the time of service.

Payments
Unless other arrangements are approved by us in writing, the balance on your statement is due and payable when the statement is issued, and is past due if not paid by the end of the month.

Past Due Accounts
If your account becomes past due, we will take steps to collect this debt. If we have to refer your account to a collection agency you agree to pay all of the collection of the balance to a lawyer, you agree to pay all the lawyer's fees which we incur, plus all court costs. You understand if your account is submitted to an attorney or collection agency, if we have to litigate in court, or if you're pat due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

Missed Appointments
We undestand that it is necessary to reschedule or cancel an appointment. We request 24 hours notice if you need to cancel your appointment, and reserve the right to charge a $25.00 cancellation fee should it be deemed necessary.

X-Rays
The fee for diagnostic x-rays is for analysis only. Should a hard copy CD be required, an additional fee may apply.

By signing and dating this document below, you agree to all of the terms and conditions contained herein.

Name_____

Signature_____ Date_____

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Patient Acknowledgement and Receipt of Notice of Privacy Practices Pursuant to HIPAA and Consent for Use of Health Information

The undersigned does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State Law and Federal Law.

The undersigned acknowledges that he/she has been advised that a full copy of this office's Notice of Privacy Practices Pursuant to HIPAA is available for review upon request.

Name_____

Signature_____ Date_____

If patient is a minor or under a guardianship order as defined by State law:

By_____
Signature of Parent/Guardian (circle one)

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