Pediatric Intake Form

Child's Name____________________________________ Parent(s) Name________________________________

Child's Date of Birth________________ Age_________ M / F Height________ Weight_ ___________

Address_________________________ City_______________ Zip______ Home Phone _______________________

Parent's cell_______________________Child's pediatrician and location___________________________________

Email __________________________________ How did you hear about our office?_________________________

Reason for today's visit____

BIRTH MOTHER'S PREGNANCY

Did the mother have any injuries during the pregnancy (accidents, falls, etc.)_______________________________

Any treatment required during the pregnancy (chiro., PT, massage, etc.) __________________________________

Any health problems during the pregnancy (diabetes, pre-eclampsia, bed rest, etc.)__________________________

Any medications or drugs taken during the pregnancy____________________________ Did the mother smoke___

LABOR AND DELIVERY

Problems during labor and delivery____

Type of birth: Vaginal_____ C-Section____ Forceps____ Vacuum Extraction____ Home Birth_____

Name of Hospital/Delivery Center___________________________________ Was a Midwife or Doula used____

Length of labor____________________ Was labor induced_____________ Did the mother have an epidural_ ____

Baby's birth weight___________ Birth length__________ APGAR Scores________ Length of Hospital stay____

Problems with the baby after delivery____

CHILD'S HEALTH HISTORY

Health problems with the child now or in the past____

Accidents or injuries to the child (falls, car, sports, broken bones)____

According to the National Safety Council, approximately 50% of children fall head first from a high place during their 1st year of life (i.e. a bed, changing table, down stairs, etc.). Was this the case with your child? No Yes

Was the child breast fed__ If so, for how long________ Was the child bottle fed__ For how long_________

Current milk: Breast___ Formula/Type_____________ Cow's milk-what %_________ Soy milk___ Rice milk___

Frequency of eating_________________________ Current food/snacks__________________________________

Any known food or environmental allergies/intolerances____

Current medications_____________________________ Current behavior________________________________

Number of hours of sleep per night______ Quality of sleep: Good____ Fair_______ Poor_______

GENERAL SYMPTOMS Check symptoms the child currently has or has had in the past year

GENERAL
__ADD/ADHD
__Allergies
__Autism/Asperger's
__ Anemia
__Bed Wetting
__Behavioral Problems
__Bladder Infection
__ Broken Bones
__Cancer/Tumors
__Depression
__Diabetes
__Difficulty Sleeping
__Dizziness
__Dyslexia
__Epilepsy
__Fainting
__Growing Pains
__Heart Problems
__Hodgkin's Lymphoma
__Hyperactivity
__Juvenile Arthritis
__Nightmares
__Night Sweats
__Paralysis
__PDD
__Seizures
__Sensory Processing Challenges
__Speech Problems
__Stroke

EYE, EAR, NOSE & THROAT
__Pink Eye
__Vision Problems
__ Dizziness
__"Crossed" Eyes
__Ringing in Ears
__Hearing Loss
__Earache
__Ear Infections
__Nose Bleeds
__Sinus Problems
__Bad Breath
__Colds-Flu
__Frequent Runny Nose

RESPIRATORY
__Asthma
__Bronchitis
__Pneumonia
__Mononucleosis
__Shortness of Breath
__Cough/Wheeze
__Repeated infections/colds

GASTRO-INTESTINAL
__Poor Appetite
__Excessive Appetite
__Bloating/Gas
__Indigestion
__Nausea
__Reflux
__Constipation
__Diarrhea
__Colitis/IBS
__Hernia

HEAD, NECK and SPINE
__Headaches
__Neck Pain
__Neck Stiffness
__Torticollis
__Midback Pain
__Low back Pain
__Back Spasms
__Scoliosis
__Muscle/joint pain

ARMS and HANDS
__Shoulder Pain
__Broken Collar Bone
__Erb's Palsy
__Elbow Pain
__Dislocated Elbow
__ "Little League Elbow"
__Wrist or Hand Pain
__Numbness or Tingling in arms

HIPS, LEGS and FEET
__Buttocks Pain
__Hip Pain
__Congenital Hip Dysplasia
__Knee Pain
__Ankle or Foot Pain
__Feet/Toes turn in or out
__Bow Legs or KnockKnee
__Walks on Toes
__Flat Feet
__Limp

SKIN
__Cradle Cap
__Baby Acne
__Eczema
__Psoriasis
__Hives
__Rash
__Bumps on back of arms or legs
__Dark circles under eyes or puffiness

CHILDHOOD ILLNESSES
__Chicken Pox
__Colic
__Croup
__Diptheria
__Measles
__Mumps
__RSV
__Rubella
__Tetanus
__Whooping Cough

OTHER:

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Authorization for care of a minor: I hereby authorize Parker River Chiropractic & Wellness and its doctors to administer care as they deem necessary to my son/daughter/ward. I accept responsibility for payment for services rendered. The patient information given is true and complete to my knowledge. I authorize the doctor to take progress photos of my child to be kept in their medical chart.

Signature____ Relationship_________________ Date_____________

Witnessed____ Date_____________________

Authorization for the Release of Medical Records

Authorized Release of Records to Primary Care Physician

Patient Name ___________________________________ Date of Birth ____________________

I hereby authorize Parker River Chiropractic & Wellness to release health care information regarding my treatment to the physician listed below. I understand that records may be released while I am under care per my request to my physician.

Primary Care Provider Information

Doctor Name/Practice Name ____
Address ____
City ________________________________ State ___________________ Zip ________________
Phone _________________________ Fax ________________________

Patient Signature____

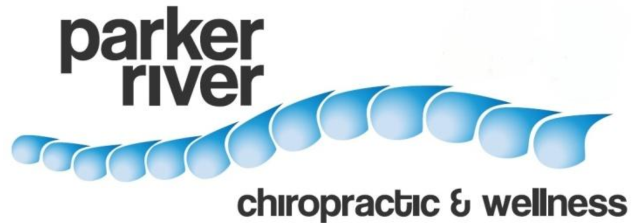
Authorized Release of Medical Records from other Providers

I hereby authorize Parker River Chiropractic & Wellness to obtain any of the following medical records from my previous or concurrent medical providers: X-ray, MRI, CT films and reports, SOAP notes, prescriptions, lab tests and any other necessary medical records.

I hereby authorize the following medical facilities to release medical information pertinent to the management of my health.

Doctor Name/Facility Name ____
Address ____
City ___________________________________ State _________________ Zip _______________
Phone _________________________ Fax ________________________

Patient Signature____



INFORMED CONSENT TO CHIROPRACTIC TREATMENT

I hereby request and consent to the performance of chiropractic adjustments and any other chiropractic procedures, including examination tests, diagnostic x-ray(s) and physical therapy techniques, on myself (or on the patient named below for which I am legally responsible) which are recommended by the Doctor(s) of Chiropractic at Parker River Chiropractic & Wellness.

I understand that, as with any health care procedure, there are certain complications, which may arise during a chiropractic adjustment. Those complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. I do not expect the doctor to be able to anticipate all risks and complications and I wish to rely on the doctor to exercise judgment during the course of the procedure(s) which the doctor feels at the time, based upon the facts then known, are in my best interest.

I have had an opportunity to discuss with the doctor at Parker River Chiropractic & Wellness and/or with office personnel, the nature, purpose and risks of chiropractic adjustments and other recommended procedures and have had my questions answered to my satisfaction. I understand that the results are not guaranteed.
I have read ( ) or have had read to me ( ) the above explanation of the chiropractic adjustment and related treatment. By signing below I state that I have weighed the risks involved in undergoing treatment and have myself decided that it is in my best interest to undergo the chiropractic treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions(s) for which I seek treatment.

____ ____________________________
Signature of Patient or Guardian Date

ASSIGNMENT OF INSURANCE BENEFITS

I request payment of insurance and/or Medicare benefits be made on my behalf to Parker River Chiropractic & Wellness. If these payments are made out to me directly, I grant the Parker River Chiropractic & Wellness the full power and authority in my name and stead to endorse any and all checks, drafts of money orders.

I understand all copayments are due at the time of service.

I understand there is no guarantee that my insurance company or pre-paid health plan will cover or pay for all of my charges. I understand that I am financially responsible for any treatment or balances not paid by my insurance company.

____ ____________________________
Signature of Patient of Guardian Date

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge receipt of 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, obtain payment from third party payors and conduct normal healthcare operations such as quality assessments and accreditation.

____ ____________________________
Signature of Patient of Guardian Date