PEDIATRIC CHIROPRACTIC INTAKE FORM

Thank you for allowing us the opportunity to take care of you and your family. Please complete the following information so we can better serve your child. It is a pleasure to welcome you to our chiropractic family.

Child's Name_____DOB_____/_____/_____Age_____

Sex M / F Height_____ Weight_____ # of Siblings_____

Name of Parents/Guardians_____

Address_____City/State/Zip_____

Mother's Cell_____ Father's Cell_____

Parent email_____

How did you hear about our office?_____

Reason for today's visit_____

Other doctors you have seen for this visit_____

Prior treatment_____

OTHER HEALTH PROBLEMS

Please check any current or past health problems your child has had on the list below:

___Dizziness	___Diabetes	___Anemia	___Broken bones
___ADHD	___Rheumatic Fever	___TB	___Sprains/strains
___Autism	___Poor appetite	___Fainting	___Hypertension
___Backaches	___Hyperactivity	___Arthritis	___Hernia
___Neck pain	___Elbow/arm pain	___Heart condition	___Behavioral issues
___Headaches	___Rashes	___Poor memory	___Leg/hip pain
___Allergies	___Digestive issues	___Insomnia	___Knee/foot pain
___Asthma	___Sinus issues	___Nightmares	___Growing pains
___Runny nose	___Neuritis	___Bed wetting	___Joint pain
___Itchy eyes	___Cough/Wheeze	___Pain while urinating	___Scoliosis
___Chronic ear infections	___Chest pain	___Convulsions	___Blood disorders
___Frequent colds	___Constipation	___Paralysis	___Stomachaches
___Fever/chills	___Diarrhea	___Muscle pain	___Other_____

HEALTH HISTORY

Previous chiropractor_____Reason for care_____

Name of pediatrician_____Date of last visit_____

Reason for last visit_____

Current medications_____

Has your child been injured in any type of accident (i.e. sports, car accident, major fall, etc) Y / N

If yes, please describe with dates_____

_____

Prior surgeries with dates_____

_____

PRENATAL HISTORY

Childbirth caregiver(s): OB/GYN_____ Doula_____ Midwife_____

Location of birth: Hospital_____ Home_____ Birth Center_____

Medication used during birth: None_____ Pitocin_____ Epidural_____

Interventions during birth: Breaking water_____ Vacuum_____ Forceps_____

Position of baby at birth: Head down_____ Posterior_____ Breech_____

Length of labor:_____

Complications during pregnancy_____

Complications during delivery_____

Birth weight_____ Birth height_____

FEEDING HISTORY

Breast fed: Y / N How long_____

Formula fed: Y / N How long_____

Type of formula_____

Introduced solids at _____ months Cow's milk at _____ months

Food allergies/intolerances Y / N _____

DEVELOPMENTAL HISTORY

Number of hours of sleep per night _____ Quality of sleep: Good / Fair / Poor

At what age was your child able to:

Respond to sound_____	Follow object with eyes_____	Hold head up_____
Crawl_____	Sit alone_____	Roll over_____
Walk alone_____	Say words_____	

WE ARE HERE TO SERVE YOU AND ENCOURAGE YOU TO ASK QUESTIONS.
YOUR PARTICIPATION IS VITAL AND WILL HELP DETERMINE YOUR CHILD'S RESULTS.

Insurance carrier_____

Policy holder name_____ DOB_____

AUTHORIZATION FOR CARE OF A MINOR

I hereby authorize this office and its Doctor(s) to administer care to my son/daughter as they deem necessary. I clearly understand and agree that I am personally responsible for payment of all fees charged by this office.

_____

Parent/guardian print Signature Date

Informed Consent

PATIENT NAME:_____ Date of Birth:_____

To the patient: Please read this entire document prior to signing. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The nature of the chiropractic adjustment.

The primary treatment i use as a Doctor of Chiropractic is spinal manipulative therapy. I may use my hands or a mechanical instrument called an Activator in order to move your joints to improve their function, alignment and reduce nearby nerve irritation. You may feel a "click" or "pop," and you may feel movement of the joints during the adjustment. Various ancillary procedures, such as massage, trigger point therapy, hot or cold packs, electric muscle stimulation, therapeutic ultrasound, or rehab exercises may also be used to aid in treatment and to prepare your body for the adjustments.

Possible risks and probability of those risks occurring.

By any standard, chiropractic adjustment is a conservative and very safe procedure. Chiropractic, as well as all other health professions, is associated with potential risks in the delivery of treatment. Therefore it is necessary to inform the patient of such risks prior to initiating care. While Chiropractic treatment is remarkably safe, you need to be informed about the potential risks related to your care to allow you to be fully informed before consenting to treatment. Chiropractic is a system of health care delivery and therefore, as with any health care delivery system, I cannot promise a cure for any symptom, condition, or disease as a result of treatment in this office.

Although generally described as rare, chiropractic adjustments and physical therapy procedures may be accompanied by post treatment soreness, disc injury aggravation, muscle strains, minor burns to the skin while receiving moist heat, rare rib injury or fracture or in very rare incidents (with high risk patients) stroke. Precautions such as pre-treatment history, examination and diagnostic x-rays as needed prior to care minimize such risks, as well as performing all treatment carefully. Some patients will feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to our attention, it is your responsibility to inform me.

Risks of remaining untreated.

Remaining untreated or delay of treatment may increase complications that include the formation of adhesions, scar tissue and other degenerative changes. These changes decrease joint motion and may lead to chronic pain. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

I do not expect the doctor to anticipate, nor explain all of the risks, and/or complications that are possible, but I will rely on the Doctor's training and education which she feels necessary, based on the facts and diagnosis in my case, knowing that she will act in my best interest.

Acupuncture treatment

Acupuncture attempts to normalize physiological functions, to modify the perception of pain, and to treat certain diseases and dysfunctions of the body. I have been informed that acupuncture is a safe method of treatment, but it may have side effects, including bruising, numbness or tingling near the needling sites that may last a few days and dizziness or fainting. I understand that I should not move while the needles are being inserted, during treatment, or when the needles are being removed. Unusual risks of acupuncture include lung puncture (pneumothorax) if acupuncture is performed in the region of the lung. Infection is another possible risk, although the acupuncturist below uses sterile disposable needles and maintains a clean safe environment. I understand that while this document describes the major risks of treatment, other side effects and risks may occur. **I will notify the doctor who is caring for me if I am or become pregnant. Although acupuncture is safe to use during pregnancy, there are some acupuncture points to be avoided in pregnancy. I will also notify the doctor if I have a bleeding disorder, if I am taking anticoagulants or other medication.**

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.

I have read, or have had read to me, the above explanation. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended realizing that no guarantees can be made regarding the outcome of treatment. Having been informed of the risks, I hereby give my consent to treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

_____ _____

Patient's Name **Date**

_____ _____

Patient's Signature (or Parent/Guardian) **Print name of Parent or Guardian (if a minor)**

NOTICE OF PRIVACY PRACTICES—ACKNOWLEDGEMENT & CONSENT TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Use and Disclosure of your Protected Health Information

Your Protected Health Information will be used by Gerhardson Chiropractic or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Notice of Privacy Practices

You should review the Notices of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. You may review the Notice prior to signing this consent. You may request a copy of the Notice at the Front Desk.

Requesting a Restriction on the Use or Disclosure of Your Information

You may request a restriction on the use or disclosure of your Protected Health Information.

This office may or may not agree to restrict the use or disclosure of your Protected Health Information.

If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

By my signature below I give my permission to use and disclose my health information.

_____ _____

Patient's Name **Date**

_____ _____

Patient's Signature (or Parent/Guardian) **Print name of Parent or Guardian (if a minor)**

Pediatric Functional Form

Child's name:_____

Today's date:_____

Please check all those that apply to your child.

_____1. Has your child been more irritable?
_____2. Has your child had difficulty sleeping?
_____3. Has your child's sleeping pattern changed?
_____4. Has your child's digestion pattern changed (i.e. constipation/diarrhea)
_____5. Has your child's intake of food been less or more?
_____6. Has your child needed more parental attention/affection?
_____7. Has your child been more distant/less affectionate?
_____8. Has your child had trouble with learning or retaining information?
_____9. Has your child's attention or focus been shortened?
_____10. Has your child's balance or coordination been altered?
_____11. Have you noticed any changes in speech patterns?
_____12. Have you noticed any changes in breathing patterns?
_____13. Have you noticed any visional changes such as squinting?
_____14. Have you noticed a change in "playing" patterns?
_____15. Have you noticed any aggression/violence/acting out?
_____16. Have you noticed any changes in relationships with grandparents/daycare providers/teachers?

_____Score