Welcome to our office!

Pediatric Intake Form (Newborn to age 10)

Today's Date:_____

ABOUT THE CHILD

Name:_____ Age:_____ Birth Date:_____ Sex: M F

Address:_____ City:_____ State:_____ Zip:_____

Whom may we thank for referring the child to our office?_____

ABOUT THE PARENTS

Mother's Name:_____ Phone:_____

Father's Name:_____ Phone:_____

Home Phone:_____ Email:_____

Address (if different from above)_____

Parent's Marital Status: Single Married Divorced Widowed

Other Guardian/Contact:_____ Phone:_____

Parent or Legal Guardian's Signature:_____

REASON FOR VISIT

Circle one: Checkup Wellness Specific Condition

If Specific Condition, please specify:_____

_____

When did this condition begin?_____

Has the condition: Gotten Worse Stayed Constant Gotten Better

Does this condition interfere with: Sleep Daily Routine Other Activities

Please explain:_____

Has this condition occurred before? Yes No

Have you seen other doctors for this condition?

Name:_____

Type of Treatment:_____

Results:_____

Name of Pediatrician:_____ Clinic:_____

Phone:_____ Address:_____

What are your goals for today's visit?_____

PRENATAL HISTORY

Name of Obstetrician/Midwife:_____Facility:_____

Complications during Pregnancy?_____

Medications during Pregnancy/Delivery?_____

Alcohol/Tobacco use during Pregnancy?_____

Location of Birth: Hospital Birthing Center Home Other:_____

Birth Interventions: Forceps C-Section Vacuum Extraction

Complications during Delivery?_____

Genetic Disorders/Disabilities?_____

Birth Weight:_____ Birth Length:_____ APGAR Scores:_____

Current Weight:_____ Current Length/Height:_____

Breastfed? No Yes How Long?_____

Formula Fed? No Yes How Long?_____

Does the child prefer to feed more on one side than the other? No Yes

Age solid foods introduced?_____ Months

Age Cow's Milk introduced?_____ Months

Does the child have any food or juice allergies, sensitivities, or intolerances? No Yes

Please list:_____

HEALTH HISTORY

Has the child ever had any of the following conditions/symptoms? Please indicate **"N"** if they have the condition **NOW**, or **"P"** if they have had the condition in the **PAST**.

N= Now **P= Past**

Ear Infection___	Back Problems___	Headaches___	Hyperactivity___
Learning disorder___	Bedwetting___	Leg Problems___	Stomach Aches___
Joint Problems___	Back Problems___	Scoliosis___	Asthma___
Recurrent Fevers___	Anemia___	Poor Posture___	Muscle Pain___
Constipation/Diarrhea___	Walking Trouble___	Seizures___	Allergies___
Growing Pains___	Reflux___	Broken Bones___	Poor appetite___
Sinus Trouble___	Frequent Colds___	Colic___	Digestive Issues___
Heart Trouble___	Neck Problems___	Arm Problems___	Behavior Problems___
Trouble Sleeping___	Diabetes___	Other_____	

Does the child exercise daily? No Yes How much?_____

Does the child take vitamins or supplements? No Yes:_____

Does the child eat balanced meals? No Yes

Does the child spend more than 1 hour on TV/Computer/Video Games? No Yes

Does the child drink soda? No Yes How much?_____

Does the child experience prolonged sadness? No Yes Explain_____

The National Safety Council reports approx. 50% of children fall head-first from a high place during their first year of life. (bed, changing table, stairs, etc.) Was this the case with your child? No Yes

Explain:_____

Does the child have difficulty interacting with others? No Yes

Has the child been involved in any high impact/contact sports? No Yes:_____

Has the child ever been hospitalized or had surgery? No Yes:_____

Has the child ever been involved in a car accident or other traumatic injury? No Yes

Explain:_____

Please rate the child's stress levels from 0 (no stress) to 10 (extreme stress): 1 2 3 4 5 6 7 8 9 10

How many times has the child been prescribed antibiotics in the past 6 months?_____ Lifetime?_____

Has the child received vaccinations? No Yes

Has the child had any of the following childhood diseases?

____Chicken Pox- age____ ____Rubella- age____

____Mumps- age____ ____Whooping Cough- age____

Please list any recreational activities the child is involved in:_____

_____

FAMILY HISTORY

Please check all that apply:

____arthritis (parent)	____arthritis (sibling)	____cancer (parent)	____cancer (sibling)
____cholesterol (parent)	____cholesterol (sibling)	____diabetes (parent)	____diabetes (sibling)
____heart problem (parent)	____heart problem (sibling)	____high BP (parent)	____high BP (sibling)
____psychiatric (parent)	____psychiatric (sibling)	____thyroid (parent)	____thyroid (sibling)
____stroke (parent)	____stroke (sibling)	Other:_____	

Thank you for taking the time to give us detailed information on the child's health. This information allows us to give the child the best care we possibly can!

Patient Acknowledgement and Receipt of

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

Name_____ Date_____

Print Patient's Name

The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant To HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request.

The undersign does hereby consent to the use of his or her health information in a manner consistent with the Noti**c**e of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State law and Federal Law.

Dated this _____ day of _____, 20___

By_____

Patient's Signature

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

By_____

Signature of Parent /Guardian (circle one)

Active Family
Chiropractic & Wellness

4825 EP True Pkwy, Suite 103

West Des Moines, IA 50265

Ph: 515-225-4809 Fax: 515-440-0495

Informed Consent

I will use my hands or a mechanical instrument upon your body in such a way as to move your joints. This procedure is referred to as ”Spinal Manipulation” or “Spinal Adjustment” As the joints in your spine are moved, you may experience a “popping” sound as part of the process.

There are certain complications that may occur as a result of a spinal manipulation. These compilations include, but are not limited to: muscle strain, cervical myelopathy, disc and vertebral injury, fractures, sprains and dislocations, Bernard-Horner’s Syndrome (also known as oculosympathethetic palsy), costovertebral strains, separation and/or fracture. Rare complications include, but are not limited to stroke. The most common complication or complaint following spinal manipulation is an ache or stiffness at the site of adjustment.

I am aware of these complications, and in order to minimize their occurrence I will take precautions. These precautions include, but are not limited to my taking a detailed clinical history of you and examining you for any defect which would cause a complication. This examination may include the use of x-rays. The use of x-ray equipment may pose a risk if you are pregnant. If you are pregnant, you should tell me when I take your clinical history.

Date _____ _____

Printed Name

_____

Signature

_____

Signature of Parent or Guardian (if a minor)

Insurance Information

Policy Holder Information:

Name on card: _____

Date of Birth: _____ Relationship to the patient: _____

Address (if different than patient):_____

Please check any and all insurance coverage that may be applicable in this case**:**

Major Medical Worker's Compensation Medicaid Medicare Auto Accident

Medical Savings Account & Flex Plans Other: _____

Primary Insurance Co. Name: _____

Insurance Plan: HMO PPO Other: _____

Insurance Co. Phone: _____

Policy/Member #: _____

Group #: _____

*Please let us know if you also have a secondary insurance you would like to file

Authorization and Financial Responsibility:

I authorize the release of any medical or other information necessary to process my claims. I assign directly to Active Family Chiropractic & Wellness all insurance benefits, if any, otherwise payable to me for services rendered.

I certify that the above information is correct. I understand that I am personally financially responsible for all services not paid for by my insurance. I am also responsible for any annual deductibles applicable, copayments, or non-covered services as may be required by my insurance plan.

X_____ **X**_____

Signature of patient or person acting on patient's behalf Date