Restored Life Wellness CENTER

PEDIATRIC INTAKE FORM

Date: _____

PERSONAL INFORMATION

Child's First Name: _____ M.I.: ____ Last Name: _____

Preferred Name: _____

Address: _____ City/State/Zip: _____

Birth Date: _____ Age: _____ Sex: M F #of Siblings: _____

Sibling(s) Names & Ages: _____

_____

Parents' Names: _____

_____

Best Contact Phone: ( ) _____ Alternate Phone: ( ) _____

Email: _____

Who can we thank for referring you or how did you hear about Restored Life Wellness? _____

_____

REASON FOR SEEKING CARE

What is your reason for seeking care at Restored Life Wellness? _____

_____

_____

When did this begin? (If applicable) _____

Are there any major injuries and/or surgeries we should know about? _____

_____

_____

What is this affecting that is MOST important in your child's life? (List all that apply) _____

_____

Has your child seen any other providers for this condition? (List all that apply) _____

_____

Has your child seen a chiropractor before? Yes - No How long ago? _____

Clinic/Doctor Name: _____

What is your reason for the change? (If applicable) _____

What is your level of commitment to your child's health? 1 2 3 4 5 6 7 8 9 10

Explain: _____

What health goal, if your child were to complete or accomplish it, would have the greatest impact on his/her life? _____

_____

_____

HEALTH CONCERNS

☐ Anxiety/Depression
☐ Constipation/Diarrhea
☐ Nausea/Vomiting
☐ Diabetes
☐ Bed Wetting
☐ Overweight
☐ Frequent Sickness
☐ ADD/ADHD
☐ Detachment/Distant
☐ Irritability/Nervous
☐ Fatigue/Sleep Issues
☐ Asthma/Chronic Bronchitis
☐ Colic/Acid Reflux
☐ Back/Neck Pain/Stiffness
☐ Difficulty Gaining Weight
☐ Ear or Other Infections
☐ Headaches
☐ Learning Disorders
☐ Sinus Troubles/Allergies
☐ Autism/Asperger's

☐ Other _____
☐ Other _____
☐ Other _____

Explain any boxes checked above:

_____
_____
_____
_____
_____

Is there anything else regarding your child's current condition you feel the doctor should know? _____

_____
_____
_____
_____
_____

MEDICATIONS

☐ Anxiety/Depression
☐ Asthma
☐ Pain Narcotics
☐ Antibiotics
☐ Migraine/Headache
☐ Acid Reflux
☐ ADD/ADHD
☐ Digestive

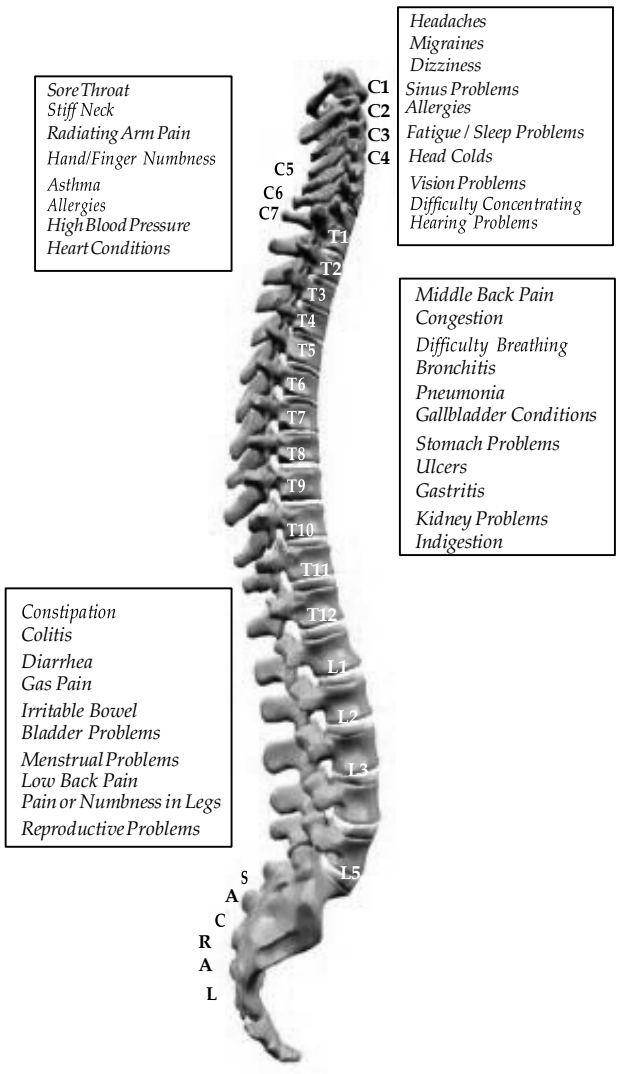
☐ Other _____
☐ Other _____
☐ Other _____

Explain any boxes checked above: _____

_____
_____
_____
_____

Did You Know...

Each health concern relates to a specific area of the spine and nervous system? Please circle below or enter the information to the left.



VITAMINS / SUPPLEMENTS

☐ Multi-Vitamin
☐ Vitamin D3
☐ Fish Oil/Omega-3
☐ Probiotics

☐ Other _____
☐ Other _____
☐ Other _____

Explain any boxes checked above:

_____
_____
_____
_____

PRENATAL HISTORY

Location of birth: Home Birthing Center Hospital Other: _____

Did any of the following happen during delivery:

C-section delivery - Doctor pulled or twisted baby - Anesthesia - Labor was induced

Forceps/vacuum extraction - Premature delivery - Special medical procedures/tests

Describe any of the above plus any additional complications experienced during delivery:

_____

During pregnancy, did you use any drugs, tobacco, alcohol, and/or medications? If yes, please list:

_____

Did you experience any illness while pregnant? Yes - No If yes, explain: _____

Do you have any physical disabilities? Yes - No If yes, explain: _____

Birth weight:_____ Birth length:_____ APGAR scores (if remembered): _____

Ultrasound used during pregnancy? Yes - No Number of times: _____

Did you breastfeed the baby? Yes - No If yes, how long: _____

Did you formula-feed the baby? Yes - No If yes, how long: _____

At what age did you introduce: Cow's milk: _____ Solids:_____

LIFESTYLE HABITS

Does your child exercise daily? Yes - No How much? _____

Does your child drink soda? Yes - No How much/often? _____

Does your child have a positive self-esteem or self-image? Yes - No

Does your child watch more than an hour of TV per day? Yes - No How much?_____

Does your child eat balanced meals? Yes - No

Does your child experience prolonged sadness? Yes - No Explain:_____

Does your child have difficulty sleeping? Yes - No Explain: _____

Does your child play video games, use cellphone/iPad? Yes - No How much? _____

CURRENT HEALTH STATUS

The National Safety Council reports approximately 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 for your child? Yes - No Explain: _____

Has your child ever been hospitalized or had surgery? Yes - No Explain:_____

Does your child have difficulty interacting with others? Yes - No Explain:_____

Have you noticed that your child is nervous, twitches, shakes, or exhibits rocking behavior? Yes - No Explain: _____

_____

Has your child been involved in any high impact/contact sports (soccer, football, martial arts, cheerleading, etc.)? Yes No

Please list: _____

Are you aware of any food allergies or intolerance? Yes - No Explain: _____

Has your child received all recommended vaccinations? Yes - No Explain: _____

Please rate stress levels on a scale of 1-10 (10 being highest):

School: 1 2 3 4 5 6 7 8 9 10 Personal: 1 2 3 4 5 6 7 8 9 10

PERMISSION TO TREAT A MINOR

I, (Parent/Guardian)_____, give Restored Life Wellness permission to examine, x-ray (if necessary), and treat_____

Minor date of birth: ___/___/_____

Parent/Guardian Signature:_____ Date: _____

Witness Signature: _____ Date:_____

PATIENT HIPAA CONSENT FORM

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to define situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment, or practice operations will be made only after obtaining your consent. You may request restrictions on your disclosures. You may inspect and receive copies of your records within
30 days with a request. You may request to view charges to your records. In the future, we may contact you for appointment reminders, announcements, and to inform you about our practice and its staff.
I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 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 and follow up with multiple healthcare providers who may be involved in that treatment directly or indirectly, obtain payment from third party payers,
and conduct normal healthcare operations such as quality assessments and physician's certificates. I have read and understand your Notice of Privacy Practices. A more complete description can be requested. I also understand that I can request, in writing, that you restrict how my personal information is used and disclosed.

Date: _____ Print Patient Name: _____

Signature:_____Relationship to Patient : _____

FINANCIAL POLICY

Our goal is to provide the highest quality of healthcare possible. In order to achieve this goal, we need your commitment as well. Restored Life Wellness Center does not take insurance. We do accept cash, check and most major credit cards.
We urge our patients to follow the doctor's recommendations for care. Please keep your appointments as scheduled or call our office within 24 hours to make any changes. In order to attain the level of achievement we both desire, care must be followed. I authorize Restored Life Wellness to release any information deemed appropriate concerning my physical condition to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred by me.
If you have any questions about our financial policies, please ask to speak to our financial officer. If you need to make special arrangements, please ask. We will never deny care to anyone based solely on ability to pay. We will do everything possible to meet your financial needs.
Advanced Beneficiary Notice of NON-Coverage (ABN). Your health insurance does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect your health insurance will not pay for items and services such as your initial visit and any chiropractic care deemed maintenance or wellness care by your carrier (as well as other items that may arise in the future). Signing below signifies that you want these items and services, but understand that they will not be billed to your insurance
company. Therefore, you are responsible for payment and cannot appeal to your insurance carrier as they were not submitted and/or billed to them. This notice gives our opinion, not an official Medicare or other insurance carrier's decision. If you have other questions, please ask our front desk. Signing below means that you have received and understand this notice.

Date: _____ Parent/Guardian Signature : _____

AUTHORIZATION FOR CARE

I hereby authorize doctors and staff at Restored Life Wellness to treat my child's condition as deemed appropriate. At Restored Life Wellness, we do not diagnose or treat any disease or condition other than vertebral subluxation and the doctor/clinic will not be held responsible for any pre-existing medical conditions. I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any staff member of Restored Life Wellness responsible for any errors or omissions that I may have made in the completion of this form.
Chiropractic, as well as all other types of health care, is associated with potential risks in the delivery of treatment. 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. Please inquire if you have further questions. Chiropractic is a system of health care delivery and therefore, as with any health care delivery system, we cannot promise a cure for any symptom, condition, or disease as a result of treatment in this office. An attempt to provide you with the very best care is our goal, and if the results are not acceptable, we will refer you to another provider who we feel can further assist you.

Date: _____ Signature: _____

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 typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

Arterial dissections occur 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.

The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events/ per one million persons/year and risk of death has been estimated as 104 per one million users.

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: