Live Well CHIROPRACTIC
Dr. Jeffrey F. Dye, D.C.

Pediatric Intake Form

Date: ___________________________

Personal Information		
Child's First Name: M.I.: Last Name:		
Preferred Name: Social Security Number: ______-_____-_______		
Address:		
City/ State/ Zip:		
Birth Date:	Age:	Sex: M or F
Sibling (s) Names & Ages:		
Parent's Name:		
Best Contact Phone: ( )		
Alternate Phone: ( )		
Email:		
Who can we thank for referring you or how did you hear about Live Well Chiropractic?		

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

Explain any boxes checked above:________________________
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Is there anything else regarding your child's current condition you feel the doctor should know?________________________
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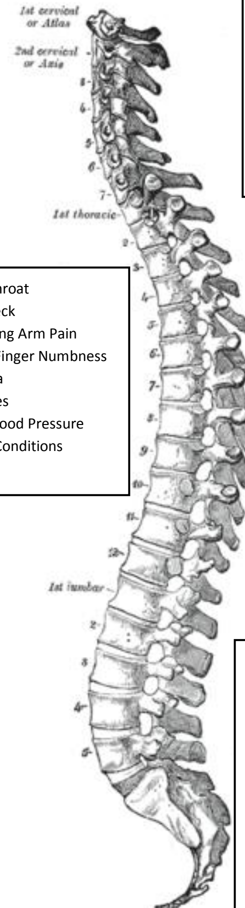

Headaches
Migraines
Dizziness
Sinus Problems
Allergies
Fatigue/Sleep Problems
Head Colds
Vision Problems
Difficulty Concentrating

Sore Throat
Stiff Neck
Radiating Arm Pain
Hand/Finger Numbness
Asthma
Allergies
High Blood Pressure
Heart Conditions

Middle Back Pain
Congestion
Difficulty Breathing
Bronchitis
Pneumonia
Galbladder Conditions
Stomach Problems
Stomach Problems
Ulcers
Gastritis
Kidney Problems
Indigestion

Constipation
Colitis
Diarrhea
Gas Pain
Irritable Bowel
Bladder Problems
Menstrual Problems
Low Back Pain
Pain or Numbness in Legs
Reproductive Problems

Medications	
☐ Anxiety/Depression	☐ Migraine/Headache
☐ Asthma	☐ Acid Reflux
☐ Pain Narcotics	☐ ADD/ADHA
☐ Antibiotics	☐ Digestive
☐ Other:____________________________________	
☐ Other:____________________________________	
☐ Other:____________________________________	

Explain any boxes checked above:______________________
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Vitamins/Supplements	
☐ Multi-Vitamin	☐ Fish Oil/Omega-3
☐ Vitamin D3	☐ Probiotics
☐ Other:__________________________	
☐ Other:__________________________	
☐ Other:__________________________	

Explain any boxes checked above:______
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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 or No If yes, explain:________________________

Do you have any physical disabilities? Yes or No If yes, explain:_________________________________

Birth Weight:_______________ Birth Length:_______________ APGAR (if remembered):______________

Ultrasound used during pregnancy? Yes or No Number of times:________________________________

Did you breastfeed the baby? Yes or No If yes, how long?____________________________________

Did you formula-fee the baby? Yes or No If yes, how long?___________________________________

At what age did you introduce: Solids:__________________ Cow's Milk:___________________________

Lifestyle Habits

Does your child exercise daily? Yes or No How much?____

Does your child drink soda? Yes or No How much/often?_____________________________________

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

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

Does your child eat balanced meals? Yes or No

Does your child experience prolonged sadness? Yes or No Explain:______________________________

Does your child have difficulty sleeping? Yes or No Explain:_____________________________________

Does your child play video games? Yes or 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? Y or N Explain:________

Has your child ever been hospitalized or had surgery? Y or N Explain:_______________________________

Does your child have difficulty interacting with others? Y or N Explain:____________________________

Have you noticed that your child is nervous, twitches, shakes, or exhibits rocking behaviors? Y or N Explain:____

Has your child been involved in any high impact/contact sports (soccer, football, martial arts, cheerleading, etc.)? Y or N List:____

Are you aware of any food allergies or intolerance? Y or N Explain:____________________________________

Has your child received all recommended vaccinations? Y or N Explain:__________________________________

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

School:________________________ Personal ____

Permission to Treat a Minor

I, (Parent/Guardian)_________________________________, give Live Well Chiropractic 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, and public health, research and law enforcement activities. Any other disclosure for the purpose 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 for our patients. In order to achieve this goal, we need your commitment as well.

- 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 Live Well Chiropractic to release any information deemed appropriate concerning my physical condition to an insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred by me.
- I authorize the direct payment to Live Well Chiropractic of any sum I now or hereafter owe by my attorney out of settlement of my case, and by any insurance company obligated to make payment to me or Live Well Chiropractic based in whole or in part upon the charges made for services received. I hereby appoint Live Well Chiropractic authority to endorse and cash checks, drafts, or money orders made payable to the undersigned or as co-payee with this clinic for payments due for services rendered on behalf of the undersigned by Live Well Chiropractic.
- In order to file your claims in a timely manner, we need current, accurate insurance information for you and your dependents. We will do our best to confirm your eligibility and level of insurance coverage for care; however, it is ultimately your responsibility to know your own insurance benefits in relation to what your insurance covers and what it doesn't. Should your insurance carrier determine that any or all of our services are ineligible for payment, you will be billed directly for those services.
- Late payment for non-coverage, deductible, and co-payments may be subject to an 18% annual finance charge, which will be added monthly to that account.
- If you have any questions about our financial policies please ask to speak to our financial officer. If you need to make special arraignments, 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 hav other questions, please ask our front desk. Signing below means that you have received and understand this notice.

Date:________________________ Signature:____

Authorization for Care

I hereby authorize doctors and staff at Live Well Chiropractic to treat my condition as deemed appropriate. At Live Well Chiropractic, 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 Live Well Chiropractic responsible for any errors or omissions that 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 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 symptoms, conditions, 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.

Signature:____ Date:____________________