



EXPRESSING LIFE CHIROPRACTIC

PEDIATRIC PATIENT INTAKE FORM

WELCOME TO OUR CLINIC. Our approach is very unique and advanced from other chiropractic programs. This allows our patients to achieve exceptional results compared to other systems.

Please fill out the following information methodically so the doctor can let you know if you are a case we can treat. We look forward to serving you.

Patient Name:

Patient Signature:

Today's Date:

"Healthy Families, Happy Lives"

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214.504.9000 PH * 214.504.9051

Pediatric Patient Questionnaire

CONFIDENTIAL PATIENT INFORMATION

Child's Name:	Parent/Guardian Name(s):		
Street Address:	City, State, Zip:		
Cell Phone:	Other Phone:	Child's Sex: <input type="radio"/> M <input type="radio"/> F	
Email:	Child's SS #:	Birthdate:	Age:
How did you hear about us?		Weight:	Height:
Who is your primary care physician?			
Is your child receiving care from any other health professionals? <input type="radio"/> Yes <input type="radio"/> No - If yes, please name them and their specialty:			
Please list any drugs/medications/vitamins/herbs/other that your child is taking:			

CURRENT HEALTH CONDITIONS

What health condition(s) bring your child to be evaluated by a chiropractor?

When did the condition first begin? _____ How did the problem start? Suddenly Gradually Post-Injury

Has your child ever received care for this condition before? Yes No
- If yes, please explain: _____

Is this condition: Getting worse Improving Intermittent Constant Unsure

What makes the problem better? _____ What makes the problem worse? _____

HEALTH GOALS FOR YOUR CHILD

What are your top three health goals for your child:	What would you like to gain from chiropractic care?
1. _____	<input type="radio"/> Resolve existing condition
2. _____	<input type="radio"/> Overall wellness
3. _____	<input type="radio"/> Both
Have you ever visited a chiropractor? <input type="radio"/> Yes <input type="radio"/> No If yes, what is their name? _____	
What is their specialty? <input type="radio"/> Pain Relief <input type="radio"/> Physical Therapy & Rehab <input type="radio"/> Nutritional <input type="radio"/> Subluxation-based <input type="radio"/> Other: _____	

PREGNANCY & FERTILITY HISTORY

Please tell us about your pregnancy

Any fertility issues? Yes No If yes, please explain: _____

Did mother smoke? Yes No If yes, how many per week? _____

Did mother drink? Yes No If yes, how many per week? _____

Did mother exercise? Yes No If yes, please explain: _____

Was mother ill? Yes No If yes, please explain: _____

Any ultrasounds? Yes No If yes, please explain: _____

Please explain any notable episodes of mental or physical stress during your pregnancy: _____

Please explain any other concerns or notable remarks about your child's conception or pregnancy: _____

LABOR & DELIVERY HISTORY

Child's birth was: Natural vaginal birth Scheduled C-section Emergency C-section At how many week's was your child born? _____

Child's birth was: At home At a birthing center At a hospital Other: _____ Doctor/Obstetrician's Name: _____

Please check any applicable interventions or complications:

Breech Induction Pain meds Epidural Episiotomy Vacuum extraction Forceps Other _____

Please describe any other concerns or notable remarks about your child's labor and/or delivery.

Child's birth weight: _____ Child's birth height: _____ APGAR score at birth: _____ APGAR score after 5 minutes: _____

GROWTH & DEVELOPMENT HISTORY

Is/was your child breastfed? Yes No If yes, how long? _____ Difficulty with breastfeeding? Yes No

Did they ever use formula? Yes No If yes, at what age? _____ If yes, what type? _____

Did/does your child ever suffer from colic, reflux, or constipation as an infant? Yes No

- If yes, please explain: _____

Did/does your child frequently arch their neck/back, feel stiff, or bang their head? Yes No

- If yes, please explain: _____

At what age did the child: Respond to sound: _____ Follow an object: _____ Hold their head up: _____ Vocalize: _____ Teethe: _____
Sit alone: _____ Crawl: _____ Walk: _____ Begin cow's milk: _____ Begin solid foods: _____

Please list any food intolerance or allergies, and when they began: _____

Please list your child's hospitalization and surgical history, including the year: _____

Please list any major injuries, accidents, falls and/or fractures your child has sustained in his/her lifetime, including the year: _____

Have you chosen to vaccinate your child? No Yes, on a delayed or selective schedule Yes, on schedule

- If yes, please list any vaccination reactions: _____

Has your child received any antibiotics? Yes No

- If yes, how many times and list reason: _____

Night terrors or difficulty sleeping? Yes No If yes, please explain: _____

Behavioral, social or emotional issues? Yes No If yes, please explain: _____

How many hours per day does your child typically spend watching a TV, computer, tablet or phone? _____

How would you describe your child's diet? Mostly whole, organic foods Pretty average High amount of processed foods

ACKNOWLEDGMENT & CONSENT

Patient Signature: _____ Date: _____

Patient Review of Systems

THE NERVOUS SYSTEM CONTROLS AND COORDINATES ALL ORGANS AND STRUCTURES OF THE HUMAN BODY

Please check the corresponding boxes for each symptom or condition you have experienced – including both past and present.



REGIONS	FUNCTIONS	SYMPTOMS					
		PAST	PRESENT				
Cervical	• Autonomic Nervous System	<input type="checkbox"/>	<input type="checkbox"/>	Colic & Excessive Crying	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy & Seizures
	• ENT System	<input type="checkbox"/>	<input type="checkbox"/>	Ear & Sinus Infections	<input type="checkbox"/>	<input type="checkbox"/>	Sensory & Spectrum
	• Vision, Balance & Coordination	<input type="checkbox"/>	<input type="checkbox"/>	Allergies & Congestion	<input type="checkbox"/>	<input type="checkbox"/>	ADD / ADHD
	• Speech	<input type="checkbox"/>	<input type="checkbox"/>	Immune Deficiency	<input type="checkbox"/>	<input type="checkbox"/>	Focus & Memory Issues
	• Immune System	<input type="checkbox"/>	<input type="checkbox"/>	Headaches & Migraines	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety & Stress
	• Digestive System	<input type="checkbox"/>	<input type="checkbox"/>	Vertigo & Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Balance & Coordination
	• Nerve Supply to Shoulders, Arms & Hands	<input type="checkbox"/>	<input type="checkbox"/>	Sore Throat & Strep	<input type="checkbox"/>	<input type="checkbox"/>	Speech Issues
	• Sympathetic Nucleus	<input type="checkbox"/>	<input type="checkbox"/>	Swollen Tonsils & Adenoids	<input type="checkbox"/>	<input type="checkbox"/>	TMJ / Jaw Pain
	• Metabolism	<input type="checkbox"/>	<input type="checkbox"/>	Vision & Hearing Issues	<input type="checkbox"/>	<input type="checkbox"/>	Stiff Neck & Shoulders
		<input type="checkbox"/>	<input type="checkbox"/>	Low Energy & Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Depression
		<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Sleeping	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure
		<input type="checkbox"/>	<input type="checkbox"/>	Pain, Numbness & Tingling in Arms to Hands	<input type="checkbox"/>	<input type="checkbox"/>	Poor Metabolism & Weight Control
	Upper Thoracic	• Upper G.I.	<input type="checkbox"/>	<input type="checkbox"/>	Reflux / GERD	<input type="checkbox"/>	<input type="checkbox"/>
• Respiratory System		<input type="checkbox"/>	<input type="checkbox"/>	Chronic Colds & Cough	<input type="checkbox"/>	<input type="checkbox"/>	Functional Heart Conditions
• Cardiac Function		<input type="checkbox"/>	<input type="checkbox"/>	Asthma			
Mid Thoracic	• Major Digestive Center	<input type="checkbox"/>	<input type="checkbox"/>	Gallbladder Pain / Issues	<input type="checkbox"/>	<input type="checkbox"/>	Indigestion & Heartburn
	• Detox & Immunity	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Pains & Ulcers
		<input type="checkbox"/>	<input type="checkbox"/>	Fever	<input type="checkbox"/>	<input type="checkbox"/>	Blood Sugar Problems
Lower Thoracic	• Stress Response	<input type="checkbox"/>	<input type="checkbox"/>	Behavior Issues	<input type="checkbox"/>	<input type="checkbox"/>	Allergies & Eczema
	• Filtration & Elimination	<input type="checkbox"/>	<input type="checkbox"/>	Hyperactivity	<input type="checkbox"/>	<input type="checkbox"/>	Skin Conditions / Rash
	• Gut & Digestion	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Problems
	• Hormonal Control	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Stress	<input type="checkbox"/>	<input type="checkbox"/>	Gas Pain & Bloating
Lumbar, Sacrum & Pelvis	• Lower G.I. (Absorption & Motility)	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>	Sciatica & Radiating Pain
	• Gut-Immune System	<input type="checkbox"/>	<input type="checkbox"/>	Chrohn's, Colitis & IBS	<input type="checkbox"/>	<input type="checkbox"/>	Lumbopelvic / SI Joint Pain
	• Major Hormonal Control	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	Hamstring Tightness
		<input type="checkbox"/>	<input type="checkbox"/>	Bed-wetting	<input type="checkbox"/>	<input type="checkbox"/>	Disc Degeneration
		<input type="checkbox"/>	<input type="checkbox"/>	Bladder & Urination Issues	<input type="checkbox"/>	<input type="checkbox"/>	Leg Weakness & Cramps
		<input type="checkbox"/>	<input type="checkbox"/>	Cramps & Menstrual Issues	<input type="checkbox"/>	<input type="checkbox"/>	Poor Circulation & Cold Feet
		<input type="checkbox"/>	<input type="checkbox"/>	Cysts & Endometriosis	<input type="checkbox"/>	<input type="checkbox"/>	Knee, Ankle & Foot Pain
		<input type="checkbox"/>	<input type="checkbox"/>	Infertility	<input type="checkbox"/>	<input type="checkbox"/>	Weak Ankles & Arches
		<input type="checkbox"/>	<input type="checkbox"/>	Impotency	<input type="checkbox"/>	<input type="checkbox"/>	Lower Back Pain
		<input type="checkbox"/>	<input type="checkbox"/>	Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>	Gluten & Casein Intolerance

Patient Name _____ 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. 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: _____

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 doctors' 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 Expressing Life Chiropractic (ELC) 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 charges incurred by me.
- Chiropractic care in this office deals with vertebral subluxation, and will therefore be billed under the S8990 adjustment code. While we will provide an itemized receipt upon your request, we anticipate that care will not be reimbursed by a third party carrier. This does not apply to PI, WSI, In-network Insurance or Medicare. HSA and FLEX spending accounts may be utilized.
- I authorize the direct payment to ELC 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 ELC based in whole or in part upon the charges made for services received. I hereby appoint ELC authority to endorse and cash checks, drafts, or money orders made payable to the undersigned or as co-payee with this clinic or payments due for services rendered on behalf of the undersigned by ELC.
- If you have any questions about our financial policies, please ask our staff. If you need to make special arrangements, please ask. 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 staff. Signing below means that you have received and understand this notice.

AUTHORIZATION FOR CARE

I hereby authorize the doctors and staff at ELC to treat my condition as deemed appropriate. At ELC, we do not diagnose or treat any disease or condition other than vertebral subluxation and the doctors/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 the doctors or any staff member of ELC 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: _____



Advanced Beneficiary Notice (ABN)

EXPRESSING LIFE CHIROPRACTIC

The purpose of this form is to help you be aware of chiropractic services in this office as it relates to any medical insurance you may have. Chiropractic care in this office is not focused on diagnosis of or relief of symptoms; it is centered on the location, analysis, and correction of underlying vertebral subluxations. Because of this, all services are coded in a manner which insurance carriers view as maintenance or wellness care and most likely will not be covered. Signing below signifies that you want the services provided in this office, 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 and policies as it relates to insurance coverage, not an official Medicare or other insurance carrier's stance or decision. Signing below indicates you have received and understand this notice.

Date: _____

Name (Printed): _____

Signature: _____

Parent/Guardian Signature (if applicable) _____