Ridge Chiropractic Center
104 Ridge Rd., Suite 144, Minooka, IL 60447

Darren Cissell, D.C.
Phone: 815-467-1464 Fax: 815-521-0492

AGE 9 AND UNDER PEDIATRIC PATIENT INTAKE FORM

Thank you for choosing Ridge Chiropractic Center

IMPORTANT: If you are using insurance to supplement your care, present your insurance card(s) to our front staff. If you are filing a claim or have a claim number for Worker's Compensation, an Auto Accident, or a Personal Injury, let our staff know immediately. *Bring any previous x-rays or MRI studies please.*

Print clearly and check the appropriate boxes. Do not skip any questions. This is an important part of establishing medical necessity.

Date _____ Whom may we thank for referring you? _____

Patient Name _____ ☐ Male ☐ Female Age _____ Birth Date _____
Last Name First Name Initial

Birth Height _____ Birth Weight _____ Current Height _____ Current Weight _____ Social Security # _____

Address _____ City _____ State _____ Zip _____

Mother's Name _____ Father's Name _____

Home Phone _____ Mom's Cell _____ Dad's Cell _____

Emergency Contact _____ Relationship _____ Phone _____

INSURANCE INFORMATION

Person Responsible for Account _____ Birth Date _____ _____
Last Name First Name Initial Insurance Company

Relationship to Patient _____ Cell Phone _____ Social Security # _____

Address (If different from patient's) _____ City _____ State _____ Zip _____

Is the patient covered by additional or secondary insurance? ☐ No ☐ Yes

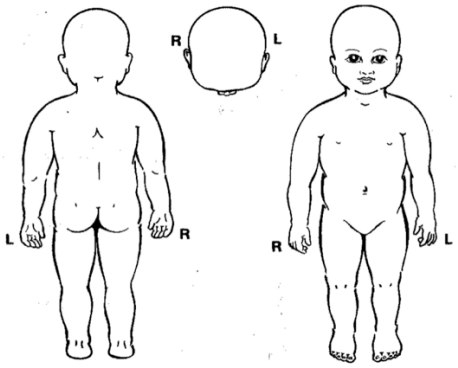
REASON FOR THIS VISIT

Purpose of this visit ☐ Pain/Discomfort ☐ Injury or Accident ☐ Check-up ☐ Other (explain) _____

Chief Complaint (If your child is experiencing Pain/Discomfort explain where) _____

_____

Below, circle all body areas of discomfort to be treated



Was the condition ☐ Gradual ☐ Sudden

When did this condition first begin? (most recent date or time period) _____

Has she/he had this before? ☐ No ☐ Yes If yes, when? _____

Does anything make it worse? ☐ No ☐ Yes If yes, list _____

_____

Does anything make it better? ☐ No ☐ Yes If yes, list _____

_____

If she/he is old enough to describe this condition, please describe _____

_____

Is the condition worse at certain time of the day or night? (check ALL that apply)

☐ Morning ☐ Afternoon ☐ Evening ☐ Night ☐ Unaffected by the time of day

What has been done to relieve her/his condition?

☐ Nothing ☐ Prescription medication ☐ Over-the-counter drugs ☐ Physical therapy ☐ Massage ☐ Ice ☐ Heat
☐ Rest ☐ Chiropractic ☐ Surgery ☐ Other (Explain) _____

Were any other doctors or therapists seen for this condition? ☐ No ☐ Yes

If yes, list all doctors or therapists, approximate date of visit(s), diagnosis, and tests findings such as X-rays, MRI's, etc. and **provide us with reports / CD's if possible**.

Name	Date of Visit	Diagnosis	Test and Findings

What is the effect of her/his condition on daily activities? ☐ Interrupted sleep ☐ Decreased appetite ☐ Incapacitation ☐ Other _____

Has she/he missed any school as a result of her/his condition? ☐ n/a ☐ No ☐ Yes (list dates) _____

Has she/he missed sports/social activities as a result of her/his condition? ☐ n/a ☐ No ☐ Yes (list dates) _____

My initials certify that the above information is true and complete to the best of my knowledge. Patient (or Guardian's) initials_____ Date_____

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Patient Name _____ Date _____

PAST MEDICAL, FAMILY AND SOCIAL HISTORY

Please list **any** health conditions / diagnosis your child has been treated for currently and in the past (list condition, cause and if it has been resolved or not)

_____

Check any of the following conditions your child has suffered **from during the past six months**: ☐ ADHD ☐ Asthma / Allergies ☐ Auto Accident

☐ Bed Wetting ☐ Chronic Colds ☐ Colic ☐ Digestive Problems ☐ Ear Infections ☐ Growing / Back Pains ☐ Headaches

☐ Recurring Fevers ☐ Scoliosis ☐ Seizures ☐ Temper Tantrums ☐ Other _____

List any childhood diseases (i.e. Chicken Pox, Mumps, Rubella, Whopping Cough, etc.) _____

Is your child currently taking any over-the-counter medications, natural supplements? ☐ No ☐ Yes (list, dose, frequency and reason)

_____

Number of doses of **Antibiotics** your child has taken: During the past 6 Months _____ Total during her/his lifetime _____

Number of doses of **Prescription Medications** your child has taken: During the past 6 Months _____ Total during her/his lifetime _____

List _____

Vaccination History _____

Previous Chiropractic care? ☐ No ☐ Yes Last visit date _____ Reason for chiropractic care _____

Name of Pediatrician _____ Last visit date _____ Reason for last visit _____

According to the National Safety Council, approximately 50% of children fall head first from a high place during their first year of life (i.e., a changing table, down stairs, a bed, etc.). Has your child fallen? ☐ No ☐ Yes (list dates and details) _____

Has or is your child been involved in any contact or high impact-type sports (i.e., baseball, gymnastics, cheerleading, football, hockey, soccer, martial arts, etc.)?

☐ No ☐ Yes (list dates and details) _____

Previous auto accident(s) EVER? ☐ No ☐ Yes (list dates and details) _____

Previous broken bones or other trauma? ☐ No ☐ Yes (list dates and details) _____

Previous surgeries, hospitalization? ☐ No ☐ Yes (list dates and details) _____

Does your child **allergies**? ☐ No ☐ Yes (please list) _____

Any family history of disease of hereditary conditions? ☐ No ☐ Yes (list details) _____

Cause of immediate family deaths and age at death _____

From birth to adolescence, your child's spine is most vulnerable to stress and should routinely be checked by a doctor of chiropractic foe prevention and early detection of vertebral subluxation (spinal nerve interference). Any concern or treatment of any physical, social, emotional and cognitive growth with your child?

☐ No ☐ Yes (please explain) _____

PRENATAL HISTORY

Name of Obstetrician / Midwife _____

Complications during pregnancy? ☐ No ☐ Yes (please list) _____

Ultrasounds during pregnancy? ☐ No ☐ Yes Number _____

Medications during pregnancy / delivery? ☐ No ☐ Yes (please list) _____

Cigarette / Alcohol use during pregnancy? ☐ No ☐ Yes

Location of birth ☐ Hospital ☐ Birthing Center ☐ Home

Birth Intervention ☐ Forceps ☐ Vacuum Extraction ☐ Caesarian Section, Emergency or Planned? (circle one)

Complications during delivery ☐ No ☐ Yes (please list) _____

Genetic Disorders or Disabilities? ☐ No ☐ Yes (please list) _____

Breast Fed ☐ No ☐ Yes How long _____ Formula Fed ☐ No ☐ Yes How long _____ Type _____

Introduced to solids at _____ months, Cow's Milk at _____ months Food / Juice Allergies or Intolerance ☐ No ☐ Yes _____

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

Is there anything else the doctor should know about in your child's past or present health and medical history and how it is affecting her/his life?

_____

My initials certify that the above information is true and complete to the best of my knowledge. Patient (or Guardian's) initials_____ Date_____

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AUTHORIZATION FOR CARE

I certify that I am the patient or legal guardian listed above. I consent to the collection and use of the above information for the use within this office of chiropractic and do hereby authorize and release the Doctor and whomever he may designate as his assistants to administer treatment, physical examination, diagnostic x-ray studies, chiropractic care, and all other therapeutic procedures provided at Ridge Chiropractic Center, by any means, method, and or techniques, the doctor deems necessary to determine and treat my or my child's condition at any time throughout the entire clinical course of my or my child's care or in accordance with this state's statutes. As with any healthcare procedure, I understand there some risks to chiropractic manipulation and therapy including, but not limited to: fractures (which are rare and generally result from some underlying bone weakness), stroke (which is exceedingly rare and estimated to occur between one in one million and one in five million cervical adjustments), spinal or disc injuries, dislocations, and strains/sprains, and am willing to accept and consent to treatment. The other complications are also generally rare. I understand that the practice of chiropractic medicine is not an exact science and that care may involve the making of judgements based on the facts known to the doctor at the time; that it is not reasonable to expect the doctor to be able to anticipate or explain all risks and complications; that an undesirable result does not necessarily indicate an error in judgement or treatment; that no guarantee as to results has been made to or relied upon by me, and the doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I wish to rely on the doctor to exercise judgement during the course of the procedure which he or she feels at the time, based on the facts then known.

CONSENT TO TREAT A MINOR: I hereby affirm that I have to legal right to select and authorize health care services for my minor child named above. (if applicable) Under the terms and conditions of my dissolution of marriage or separation, I have the legal right to select and authorize this care for my minor child without consent of my spouse/former spouse. If my authority to authorize such care is revoked or modified, I will immediately notify this office. This office observes all laws regarding a minor patient's right to consent to, and to confidentiality of, his or her health care treatment. In addition, this office follows a policy of transitioning adolescent patients to self-management of their own health. We view our office visits as an opportunity for your child to learn to take responsibility for their health care. Therefore, as appropriate by age and maturity of the patient, parents may be asked to excuse themselves for a portion of or the entire health care visit. By signing this form, the parent or responsible party acknowledges understanding of and consent to this policy. I hereby authorize Ridge Chiropractic Center and whomever they may designate as doctors, assistants, and therapists to examine and administer treatments as they deem necessary to my child in my presence or absence under normal office visit circumstances.

TERMS OF ACCEPTANCE: When a patient seek chiropractic care and we accept such a patient for care, it is essential for both to be working towards the same objective. Chiropractic has only one goal. It is only when the patient understands both the objective and the method that will be able to attain it. This will prevent any confusion or disappointment. An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation (segmental and somatic dysfunction). Our chiropractic method of correction is by specific adjustments to the spine. Health is a state of optimal physical, mental and social well-being, not merely the absence of disease. Vertebral Subluxation is a misalignment of one or more of the joints of the body. This can cause pain or alteration of nerve function and interference of the transmission of nerve impulses, lessening the body's innate ability to maintain maximal health.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation (segmental and somatic dysfunction). However, if during the course of a chiropractic spinal evaluation we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you or your child seek the services of a health care provider who specialized in that area. Regardless of what the disease is called, we do not offer to treat it nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxation (segmental and somatic dysfunction).

RADIOLOGY REPORT: I hereby consent to a full examination and x-ray studies, and also understand and **I do hereby consent to have the doctor send my x-rays out to be read professionally by a radiologist, Dr. Gregerson**, who may or may not be in my or my child's health plan, as is the standard in the medical community. Dr. Gregerson's office will bill you separately from our office, Ridge Chiropractic Center. I am only entitled to a copy of this written imaging report. I further understand and agree that the payments to the doctor for x-rays is for examination of x-rays only and agree that x-rays are the sole legal property of this practice and must be retained for a period of no less than 8 years and are kept on file where they may be seen at any time while I am a patient at this office.

HIPAA NOTICE OF PRIVACY PRACTICES: This Practice is committed to maintaining the privacy of your protected health information ("PHI"), which includes a complete description of the uses and/or disclosures of your PHI necessary for this office to provide treatment to you or your child, to obtain payment for that treatment from any involved third parties, and to carry out its health care operations as is permitted or required by law. The creation of a record detailing the care and services you receive helps this office to provide you with quality health care. This Notice also describes how you can get access to that information and details your rights regarding your PHI. This Practice's "HIPAA Notice of Privacy Practices" may be requested at any time from the front desk staff and is also provided on the Practice's web site at MinookaChiropractor.com in the tab labeled "What to Expect" under "Online Forms". PLEASE REVIEW THIS NOTICE CAREFULLY.

FINANCIAL AGREEMENT: I understand that I am financially responsible for all charges whether or not paid by insurance. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I authorize the use of my signature on all insurance submissions, and **I understand that Ridge Chiropractic Center will prepare any necessary reports and forms to assist me in collecting from the insurance company.** I further authorize Ridge Chiropractic Center to disclose all or any part of my or my child's patient records to any person or corporation which is or may be liable under a contract to the clinic or to the patient or to a family member or employer of the patient for all or part of the clinic's charge, including, and not limited to, hospital or medical services companies, insurance companies, worker's compensation carriers, welfare funds, or the patient's employer.

If my insurance will be billed, I authorize payment to be made directly to Ridge Chiropractic Center, for all benefits that may be payable under a healthcare plain or from any other collateral sources. I authorize utilization of this form or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that **I will remain financially responsible for any and all covered or non-covered services I receive at this office.** All first visit charges are payable when services are rendered, since it is impossible to determine insurance coverage without a diagnosis of severity.

I have read and fully understand the above and certify that the information I have provided is true and correct to the best of my knowledge and I will not hold the doctor or any staff member at Ridge Chiropractic Center responsible for any errors or omissions that I may have made on this form. I do hereby authorize the doctor to treat myself or my child in accordance with this state's statutes.

_____	_____	_____
Name of Patient (Printed)	Signature of Patient	Date
_____	_____	
(Signature of Legal Representative if patient a minor)	Relationship (e.g. Guardian or Parent if patient a minor)	