intouchchiropractic

Pediatric Intake

Today's Date:_____ Referred By:_____

Male Female File#_____

Patient Name:_____ Date of Birth:_____

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

Cell:_____ Home:_____ Work: _____

Email:_____ Marital Status: S M W D

Age:_____ Social Security Number:_____

Parent's Cell Number:_____ Home Number:_____

Parent's Email:_____

Parent's Employer:_____ Parent's Occupation:_____

Emergency Contact:_____ Phone Number:_____

Is the condition due to an accident? Yes No Auto At Home Other Date:_____

Would you like us to check your insurance benefits? Yes No (provide insurance card to front desk)

Appointment Reminders: oEmail oText (Phone Carrier: _____)

Method of payment: Cash Check Credit Card CareCredit

Due to changes in health insurance coverage, our policy is that payment is due at the time of service. We will provide you with an estimated insurance coverage verification on your second visit to our office for your child. In many cases, patient self billing is the fastest way for you to receive reimbursement from your insurance company. In these cases, statements will be provided to you to submit your own bills ensuring your insurance company reimburses you directly.

I authorize Intouch Chiropractic to render necessary services to me and I am responsible for all charges incurred at time of service. All charges are due at time of service.

Patient/Guardian Signature:_____ **Date:**_____

Current Health History

Height:_____ Weight:_____

Primary Complaint:_____

How long has your child had this problem? _____

When and how did this begin?_____

What makes it worse?_____ What makes it better?_____

What time of day does it bother your child the most? Morning End of Day Night Various Times

Does it interfere with? Sleep Daily Routine

How would you describe it? Dull/Aching Sharp Stabbing Burning Tingling/Numb

Please grade the intensity (10=worst possible pain): Now: 0 1 2 3 4 5 6 7 8 9 10 Average: 0 1 2 3 4 5 6 7 8 9 10

How often does it happen? <25% 25-50% 51-75% >75% of the time

Is this problem changing with time? Getting Worst Staying the Same Getting Better

Previous interventions, treatments, medications, surgery, or care you've sought for this complaint:

_____

Secondary Complaint:_____

How long has your child had this problem? _____

When and how did this begin?_____

What makes it worse?_____ What makes it better?_____

What time of day does it bother your child the most? Morning End of Day Night Various Times

Does it interfere with? Sleep Daily Routine None

How would you describe it? Dull/Aching Sharp Stabbing Burning Tingling/Numb

Please grade the intensity (10=worst possible pain): Now: 0 1 2 3 4 5 6 7 8 9 10 Average: 0 1 2 3 4 5 6 7 8 9 10

How often does it happen? <25% 25-50% 51-75% >75% of the time

Is this problem changing with time? Getting Worst Staying the Same Getting Better

Previous interventions, treatments, medications, surgery, or care you've sought for this complaint:

What is the primary stressor in your child's life? _____

For each of the conditions listed below, place a check if it applies to your child's health:

o Headaches/Migraines	o Diabetes	o Neck Pain	o Sleep Problems
o Frequent Colds	o Back Pain	o Allergies	oDepression
o Bladder Infections	o Hand Pain	o Epilepsy	oSkin Conditions
o Ear infections	o Digestive Problems	o General Fatigue	o Cancer
o Asthma	o Colic	o ADD/ADHD	o Dizziness/Fainting
o Bedwetting	o Scoliosis	o Car Accident(s)	o Seizures

List all prescription medications and doses your child is currently taking:

List all over-the-counter medications and doses your child is currently taking:

_____

List all surgical procedures your child has had:

Previous Illnesses:

_____

Has your child been hospitalized? o Yes o No _____

Has your child had significant trauma? o Yes o No _____

Has your child received vaccinations? o Yes o No _____

Prenatal History:

Complications during pregnancy? o Yes o No Describe_____

Ultrasounds during pregnancy? o Yes o No Describe_____

Medications/drugs/caffeine use during pregnancy? o Yes o No Describe_____

Cigarette/alcohol use during pregnancy? o Yes o No Describe_____

Location of birth? Hospital Birthing Center Home Adopted

Birth Intervention:

Mother induced Mother medicated (Pitocin, etc.) Caesarian section Forceps

Vacuum extracted Baby given medication after delivery

Complications during delivery? o Yes o No Describe_____

Genetic disorders or disabilities? o Yes o No Describe_____

Breastfed? o Yes o No How long?_____ Formula Fed? o Yes o No How long?_____

Food allergies? o Yes o No Describe_____

Anything else you would like us to know? _____

Patient Consent to Physical Examination and X-Rays

Prior to receiving chiropractic care in this chiropractic office, a health history and physical examination will be completed. These procedures are performed to assess your child's specific condition, his/her overall health and, in particular, his/her spinal health. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies are needed before treatment. In addition, they will help us determine if there is any reason to modify his/her care or provide him/her with a referral to another health care provider. All relevant findings will be reported to you along with a care plan to help him/her become healthier prior to beginning care.

During his/her examination, the doctor may determine that x-rays will be needed. In order to perform x-rays on any patient, our office requires the parent/guardian consent for such tests.

I understand that the doctor may need x-rays in order to diagnose his/her condition and I give permission of all needed diagnostic tests, x-rays and physical examinations.

Patient/Guardian Signature: _____ **Date: _____**

Females Only: Regarding Possibility of Pregnancy

I understand that x-rays may be needed at some point and that by signature on this form, I do hereby state that to the best of my knowledge, my child is not pregnant. It is neither suspected nor confirmed at this particular time that she is pregnant. If determined at a later date that she is pregnant, I do not hold the doctor, health care provider's associates, association, corporation, partnership, employees, agents and estate of this establishment accountable in any way.

Patient/Guardian Signature: _____ **Date: _____**

Consent for Treatment of Minors

I, being parent or guardian of _____, a minor the age of _____, do hereby authorize, request and direct Dr. Devin Young and/or Dr. Jeanett Tapia to perform an exam, x-ray and chiropractic treatment for their condition as he/she deems necessary. In addition, I give permission for the doctors to manage his/her care when I am not present to observe such care.

Patient/Guardian Signature: _____ **Date: _____**

Witness: _____