Humboldt Spine and Rehab P.C.

PEDIATRIC CHIROPRACTIC INTAKE FORM Thank you for allowing us the opportunity to take care of you and your family. Please complete the following information so we can better serve your child.

Child's Name _____ DOB: ____/____/____ Age _____ Sex M / F

Height _____ Weight _____ # of Siblings _____

Name of Parents/ Guardians _____

Address_____ City _____ State_____ Zip _____

Home Phone # _____ Mother's Cell #_____

Father's Cell # _____ Parent Email _____

How did you hear about our office? _____

Reason(s) for seeking care _____

Other doctors seen for this condition (circle) Yes / No If yes, doctor name(s) and prior treatment:

_____

HEALTH HISTORY: Please check any current or past problems your child has had on the list below:

__Dizziness	__Diabetes	__Anemia	__Broken Bones	__ADHD
__Tuberculosis	__Rheumatic Fever	__Sprains/Strains	__Autism	__Sinus
__Hypertension	__Poor Appetite	__Fainting	__Backaches	__Scoliosis
__Hyperactivity	__Hernias	__Neck pain	__Paralysis	__Convulsions
__Heart Condition	__Behavioral	__Arm/Elbow Pain	__Headaches	__Diarrhea
__Rashes/Hives	__Poor Memory	__Leg/Hip Pain	__Allergies	__Muscle Pain
__Digestive Problems	__Insomnia	__Knee/Foot Pain	__Asthma	__Neuritis
__Constipation	__Nightmares	__Growing Pains	__Runny Nose	__Arthritis
__Bed Wetting	__Joint Pain	__Itchy Eyes	__Cough/Wheeze	__Fever/Chills
__Pain Urinating	__Chest Pain	__Blood Disorders	__Frequent Colds	__Stomach Pain

Other:

_____

Name of Pediatrician: _____ Date of last visit: _____
Number of antibiotics taken in lifetime:_____ Condition(s) treated: _____
Medications and conditions being treated: _____
Has your child been injured in any type of accident (ie. Sports, car accident, major fall, etc.)? Y/N
If yes, please describe with dates:_____
Prior surgeries? Y/N Type and Date: _____
Vaccination History: _____

PRENATAL HISTORY
Childbirth caregiver(s): OB/GYN _____ Doula _____ Midwife _____
Location of birth: Hospital _____ Home _____ Birth Center _____
Medications used during birth: None _____ Pitocin _____ Epidural _____
Interventions used during birth: Breaking of water ____ Vacuum _____ Forceps ____ Episiotomy _____
Position of baby at birth: Head down _____ Posterior _____ Breech or malposition _____
How long was your labor? _____
Complications during pregnancy: Y/N If yes, Please describe_____
Complications during delivery: Y/N If yes, Please describe: _____
Did you have chiropractic care during your pregnancy? Y/N
Cigarette/Alcohol use during pregnancy: Y/N
Ultrasound during pregnancy: Y/N
Cesarean: Y/N Planned _____ Emergency _____
Genetic Disorder/Disability? Y/N If yes, Please describe: _____
Birth weight _____ Birth length _____
APGAR scores (if known):_____

FEEDING HISTORY
Breast Fed: Y/N How long? _____ Formula Fed: Y/N
How long? _____Type of formula:_____
Introduced to solids at _____ months, Cow's milk at _____ months
Food/ juice allergies or intolerances: Y/N Please List: _____

DEVELOPMENTAL HISTORY
Number of hours sleeping per night _____ Quality of sleep: Good / Fair / Poor
Check what your child able is able to do up to this point:

___Respond to sound	___Follow object with eyes	___Hold head up
___Crawl	___Sit alone	___Stand alone
___Walk alone	___Say words	

CHILDHOOD DISEASES
At what age (if ever) did your child suffer from the following:
Chicken Pox ___ Rubella___ Measles___ Mumps___ Whooping Cough___ Other_____

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

Parent/Guardian Signature:_____ Date:_____

Verified by:_____ Date:_____

Humboldt Spine
and Rehab P.C.
702 13th St. N.
Humboldt IA 50548
(515) 332-7990

Patient Name: _____ **Date:** _____

Terms of Acceptance

The goal of our office is to enable patients to gain control of their health. To attain this we believe communication is the key. There are often topics that are hard to understand and we hope this document will clarify those issues for you.

Please read the below and if you have any questions please feel free to ask one of our staff members.

Informed Consent:

A patient, in coming to the chiropractic doctor, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or care if he/she is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known, or to learn through healthcare procedures what he/she is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the chiropractic physician. The chiropractic doctor provides a specialized, non-duplicating health care service. Your doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regimen. I understand that if I am accepted as a patient by a physician at Humboldt Spine & Rehab, I am authorizing them to proceed with any treatment that they deem necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

Office Policy:

There is a possible fee charged for all appointments that are not canceled prior to scheduled visit. If the account balance exceeds $150, services may be withheld.

Communications:

In the event that we would need to communicate your healthcare information, to whom may we do so?

Spouse: _____

Children: _____

Others: _____

No one: ____

May we leave messages regarding your personal healthcare information on any answering device, i.e. home answering machines or voicemails? Yes [ ] No [ ]

Acknowledgement

I have read and fully understand the above statements. I have reviewed the notice of privacy practices (HIPAA) and have been provided an opportunity to discuss my right to privacy. Upon request I will be given a copy.

Print Name: _____

Signature: _____ Date: _____

Consent to Evaluate and Treat a Minor:

I, _____ being the parent or legal guardian of _____, have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Signature: _____ Date: _____