PEDIATRIC INTAKE & HISTORY

PATIENT INFORMATION

Patient Name____________________ Mother's Name ____________________
Address____________________ Mother's Occupation ____________________
City____________________State__________ Mother's Phone ____________________
Home Phone____________________ Mother's Email ____________________
Cell Phone ____________________
Email____________________ Father's Name ____________________
Sex ☐ M ☐ F Age _____ Birthday__________ Father's Occupation ____________________
IN CASE OF EMERGENCY, CONTACT Father's Phone ____________________
Name____________________ Father's Email ____________________
Relationship____________________ Who may we thank for referring you?
Contact Number ____________________ ____________________

HOW CAN WE HELP YOUR CHILD?

☐ Wellness Checkup ☐ Other: ____________________

If your child is already experiencing a symptom, please describe it:

Has your child been treated on an emergency basis? ☐ Yes ☐ No

Please describe: ____________________

PREGNANCY HISTORY

Did you experience any complications during your pregnancy? (check all that apply)

☐ Back/Other Pain ☐ Gestational Diabetes ☐ Pre/Eclampsia ☐ Strep B ☐ Nausea/Vomiting

☐ Pre-Term ☐ Fatigue ☐ Swelling ☐ Other (please describe) ____________________

BIRTH HISTORY

Type of birth (check all that apply):

☐ Hospital ☐ Birth Center ☐ Home ☐ Normal / Vaginal ☐ Breech

☐ Cesarean ☐ Scheduled/Induced ☐ Epidural

Problems during labor / delivery? ____________________

☐ Antibiotics ☐ Congenital Anomalies ☐ Failure to Thrive ☐ Jaundice ☐ Meconium

☐ Respiratory Distress ☐ Extended Hospitalization ☐ Other ____________________

GROWTH & DEVELOPMENT

Infant feeding: ☐ Breast ☐ Bottle ☐ Formula

Number of hours of sleep each night: ____________ Quality of sleep: ____________

At what age did the child:

Respond to sound: ____________ Crawl: ____________ Hold head up: ____________

Stand: ____________ Sit unsupported: ____________ Walk unsupported: ____________

CHILDHOOD DISEASES, ILLNESSES & VACCINATIONS

Has your child had (check all that apply)?:

☐ Chicken Pox ☐ Measles ☐ Robiola

☐ Mumps ☐ Rubella ☐ Pertussis/Whooping Cough

Has your child ever suffered from (check all that apply)?:

☐ Allergies
☐ Anemia
☐ Arm Problems
☐ Asthma
☐ Back Aches
☐ Bed Wetting
☐ Behavioral Problems
☐ Broken Bones
☐ Chronic Earaches
☐ Colds/Flu
☐ Colic
☐ Convulsions/Seizures
☐ Delayed Speech
☐ Diabetes
☐ Digestive Issues (constipation/diarrhea)
☐ Dizziness
☐ Fainting
☐ Headaches
☐ Heart Trouble
☐ Hyperactivity
☐ Hypertension
☐ Juvenile / Rheumatoid Arthritis
☐ Joint Problems
☐ Leg Problems
☐ Neck Problems
☐ Neuritis
☐ Orthopedic Problems
☐ Paralysis
☐ Poor Appetite
☐ Ruptures/Hernias
☐ Sinus Trouble
☐ Tuberculosis
☐ Walking Problems

Have you vaccinated your child?

☐ No ☐ Yes ☐ As Scheduled ☐ Delayed Schedule

ALLERGIES, MEDICATIONS, SURGERIES & FAMILY HISTORY

ALLERGIES (list)

____

____

MEDICATIONS (list)

____

____

SURGERIES (list)

____

____

FAMILY HISTORY (list)

____

____

SIBLINGS

How many children do you have? ____________

Children's Ages: ____________

Children's health concerns: ____________

____

Number of pregnancies: ____________

Are you currently pregnant? ☐ No ☐ Yes, I'm due: ____________

Health concerns regarding this pregnancy? ____________

____

Insurance Information

If you have insurance information please provide the staff with your card.

Insurance Patients I understand and agree that health and accident insurance policies are an arrangement between the insurance carrier and myself. I authorized the release of any medical information necessary to process this claim and authorize payment of services to this office. I understand any amount paid directly to the office will be credited to my account. I permit this office to endorse co-issued remittances for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered me are charged directly to me and I am personally responsible for payment. Please make payment for your portion of charges at each visit unless other arrangements are made.

Patient's Signature ______________________________ Date ______________

Patients Without Insurance Please pay for services at the time of each visit. We accept Visa, MasterCard, checks or cash. If you prefer, a payment plan will be set up for your convenience.
Let us know which one you prefer. (check one) _____ Payment at time of service _____ Payment Plan

Patient's Signature ______________________________ Date ______________
(signature of parent or guardian if the patient is a minor)

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease. We only offer to diagnose either vertebral subluxations or neuro-musculoskeletal conditions. However, if during the course of a chiropractic spinal examination, 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 seek the services of another health care provider.

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 subluxations. However, we may use other procedures to help your body hold the adjustments.

I have read and fully understand the above statements. All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis.

______________________ ______________________
(signature) *(date)*

Consent to Evaluate and Adjust a Minor Child

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)*

Financial Policy

It is the goal of this office to provide you the FINEST QUALITY CHIROPRACTIC CARE available. We welcome your referrals and look forward to a doctor-patient relationship that works for our mutual benefit.

- I hereby acknowledge and understand that all charges incurred at Kingen Chiropractic Wellness Center are my responsibility.
- In the event that it becomes necessary for Kingen Chiropractic Wellness Center or it's agents to employ legal and/or collection counsel, I understand and agree I am responsible for payment of all collections and attorney's fees, which will be added to my account/bill.
- All returned check will be charged a $25.00 service fee, plus any additional fees (i.e. bank fees, collection fees, etc...)

I have read and understand everything described in the Financial Policy, and all of my questions have been answered to my full satisfaction in a way that I can understand.

______________________________ Name of Individual (printed)

______________________________ Signature of Individual

______________________________ Witness

______________________________ Date Signed

Patient Acknowledgement
For us and/or disclosure of Protected Health Information (PHI)
To carry out treatment, payment and healthcare operations

I hereby state that by signing this consent, I acknowledge and agree as follows:

1. The practice's Privacy Notice has been provided to me prior to signing this consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information (PHI) necessary for the practice to provide treatment to me, and also necessary for the practice to obtain payment for that treatment and to carry out its healthcare operations. The practice further explained to me my right to obtain a copy of this privacy notice prior to signing this consent and has encouraged me to read the privacy notice carefully prior to my signing this consent.
2. The practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.
3. The practice's "Notice of Privacy Practices" is also provided in the patient bookcase and on the practice's website at www.kingenchiropractic.com. I may request a copy from this office at any time via USPS, but will be personally responsible for copy fees and any postage due.
4. This Notice of Privacy Practices also describes my rights and the duties of this office with respect to my protected healthcare information.

I have read and understand everything described in the Patient Acknowledgement (PHI) and all my questions have been answered to my full satisfaction in a way that I can understand.

______________________________ Name of Individual (printed)

______________________________ Signature of Individual

______________________________ Witness

______________________________ Date signed