Woodbury Family Chiropractic

PEDIATRIC INTAKE FORM

Child's First Name: ___________________________ M.I.: _______ Last Name: ______________________________

Preferred Name: ________________________ Address: ____
City / State / Zip: ____
Birth Date: _________________________ Age: ________________ Gender: **M** **F**
Sibling(s) Names & Ages: ____
Parents' Names: ____
Best Contact Phone: _______________________________________ Cell or Home / Mom or Dad
Alternate Phone: ____ Cell or Home / Mom or Dad
Email: ____

Who can we thank for referring you or how did you hear about Woodbury Family Chiropractic?
____
What is your reason for seeking care at Woodbury Family Chiropractic? ____________________________________
When did this begin? (if applicable) ____
Are there any major injuries and/or surgeries we should know about? ______________________________________
____
What is this affecting that is MOST important in your child's life? (List all that apply) _________________________
____
Has your child seen any other providers for this condition? (List all that apply) ______________________________
____
Has your child seen a chiropractor before? **Yes** **No** If yes, how long ago? __________________
Clinic/Doctor Name: ____
What is your reason for the change? (if applicable) ____

Check All That Apply to Your Child:

☐ Anxiety/Depression ☐ Fatigue/Sleep Issues ☐ Constipation/Diarrhea ☐ Asthma/Chronic Bronchitis
☐ Nausea/Vomiting ☐ Colic/Acid Reflux ☐ Diabetes ☐ Back/Neck Pain/Stiffness ☐ Bed Wetting
☐ Difficulty Gaining Weight ☐ Overweight ☐ Ear or Other Infections ☐ Frequent Sickness ☐ Headaches
☐ ADD/ADHD ☐ Learning Disorders ☐ Detachment/Distant ☐ Sinus Troubles/Allergies ☐ Autism/Asperger's
☐ Irritability/Nervous ☐ Other: ____
Explain any boxes checked above (optional): ____

Is there anything else regarding your child's current condition you feel the doctor should know? ____________________
____
Please list any medications your child takes: ____

VITAMINS / SUPPLEMENTS:

☐ Multi-Vitamin ☐ Fish Oil/Omega-3 ☐ Vitamin D-3 ☐ Probiotics ☐ Other: _____________________________

PRENATAL / PEDIATRIC HISTORY

Any complications experienced during delivery (check all that apply):

☐ C-section delivery
☐ Doctor pulled or twisted baby
☐ Anesthesia
☐ Labor was induced

- ☐ Forceps/vacuum extraction
- ☐ Premature delivery
- ☐ Other: ___________________________________
- ☐ Special medical procedures/tests
- ☐ Pushed for less than 20 minutes
- ☐ Pushed for more than 2 hours

During pregnancy, did you use any drugs, tobacco, alcohol, and/or prescription medications? **Yes** **No** If yes, please list:
____

Did you experience any illness while pregnant? **Yes** **No** If yes, explain: ________________________________

Birth weight: _______________ APGAR scores (if remembered): _________

Did you breastfeed the baby? **Yes** **No** If yes, how long? ______________

Did you formula-feed the baby? **Yes** **No** If yes, how long? _____________

At what age did you introduce: Solids? __________ Cow's milk? _____________

Does your child exercise daily? **Yes** **No** **N/A** If yes, how much? _______________

Does your child watch *more* than an hour of TV per day? **Yes** **No** If yes, how much? ________________

Does your child play video games? **Yes** **No** If yes, how much? ____________________

Does your child eat balanced meals? **Yes** **No** If no, please explain: ________________________________

Does your child drink soda? **Yes** **No** If yes, how much/often? ________________________

Does your child experience prolonged sadness? **Yes** **No** If yes, please explain: __________________________

Does your child have difficulty sleeping? **Yes** **No** If yes, please explain: ________________________________

The National Safety Council reports approximately 50% of children fall head first from a high place during their first year of life (bed, changing table, stairs, etc.) Was this the case for your child? **Yes** **No** If yes, please explain:
____

Has your child ever been hospitalized or had surgery? **Yes** **No** If yes, explain: _______________________________

Does your child have difficulty interacting with others? **Yes** **No** If yes, explain: ____________________________

Have you noticed that your child is nervous, twitches, shakes, or exhibits rocking behavior? **Yes** **No** If yes, explain:
____

Has your child been involved in any high impact/contact sports (soccer, football, martial arts, cheerleading, etc.)? **Yes** **No**
If yes, please list: ____

Are you aware of any food allergies or intolerance? **Yes** **No** If yes, explain: _________________________________

Has your child received all recommended vaccinations? **Yes** **No** If no, please explain: ________________________

Please rate stress levels on a scale of 1-10 (10 being highest):

School: 1 ◆ 2 ◆ 3 ◆ 4 ◆ 5 ◆ 6 ◆ 7 ◆ 8 ◆ 9 ◆ 10

Personal: 1 ◆ 2 ◆ 3 ◆ 4 ◆ 5 ◆ 6 ◆ 7 ◆ 8 ◆ 9 ◆ 10

Consent for Purposes of Treatment, Payment, and Healthcare Operations

I, __________________________ [Name of Individual] consent to Woodbury Family Chiropractic, “the Practice’s”, use and disclosure of my Protected Health Information for the purpose of providing treatment to me, for purposes relating to the payment of services rendered to me, and for the Practice’s general healthcare operations purposes. Healthcare operations purposes shall include, but not be limited to, quality assessment activities, credentialing, business management and other general operation activities. I understand that the Practice’s diagnosis or treatment of me may be conditioned upon my consent as evidenced by my signature on this document.

For purposes of this Consent, "Protected Health Information" means any information, including my demographic information, created or received by the Practice, that relates to my past, present, or future physical or mental health or condition; the provision of health care to me; or the past, present, or future payment for the provision of health care services to me; and that either identifies me or from which there is a reasonable basis to believe the information can be used to identify me. I understand I have the right to request a restriction on the use and disclosure of my Protected Health Information for the purposes of treatment, payment or healthcare operations of the Practice, but the Practice is not required to agree to these restrictions. However, if the Practice agrees to a restriction that I request, the restriction is binding on the Practice. I understand I have a right to review the Practice’s Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes my rights and the Practice’s duties regarding the types of uses and disclosures of my Protected Health Information. I have the right to revoke this consent, in writing, at any time, except to the extent that Physician or the Practice has acted in reliance on this consent.

_______________________________________ _______________________________
Signature of Patient or Personal Representative Date

____
Name of Patient or Personal Representative

Financial Policy

WELCOME TO OUR OFFICE! Our goal is to provide you with the best possible chiropractic care, and to have it be a pleasant, positive experience for all of us. In order to serve you more effectively, we have established a few policies.

APPOINTMENTS: Your appointments are times reserved and committed exclusively for you. We realize that emergencies do occur, and appointments must sometimes be changed. Charges may be made for missed appointments and appointments cancelled without 2 hours advance notice.

PAYMENTS: Payment is due at the time services are rendered, unless other arrangements have been made in advance. We accept cash, check, or VISA/MC/Discover. Returned checks are subject to a $25 service charge. Any account that becomes delinquent will be subject to collections service. Should our clinic receive information that your insurance will no longer be covering services, such as in the incidence of maximum insurance payout met, you will be charged the applicable discounted cash rates that are due at time of service and supplied receipts if needed.

INSURANCE: We must emphasize that as chiropractic providers, our primary relationship is with you. As a service to our patients, we do accept assignment of insurance benefits on most policies. In addition, we are participating providers with several insurance carriers and payers. You are responsible for payment of your co-pay at the time of service. If your deductible has not been met, you are responsible for full payment until it has been met; then, only your portion thereafter. Once the claim has been processed by your insurance provider, we will bill you your patient responsibility portion. Payment is due within 30 days of this bill.

** NOTE: We are happy to assist you in verifying chiropractic benefits of your particular policy. All insurance companies begin verification with a pre-recorded message which states: *"This verification of benefits is not a guarantee of payment. This is a simple overview of the policy. Only when a claim is received can it be reviewed for medical necessity and for policy provisions. Again, this is not a guarantee of payment."*

The primary treatment used by doctors of chiropractic is spinal manipulative therapy. This form of treatment is typically performed by hand or with a mechanical instrument upon your body in such a way to improve motion and function within your joints. After performing a physical examination and medical consultation, the Doctor will make every effort to screen for contraindications to this type of care. However, if you have a condition that would otherwise not come to the Doctor's attention, it is your responsibility to inform the Doctor.

Please ask questions before signing this form if there is anything that is unclear.

I have read all the information on this form and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you IMMEDIATELY of any changes in my health status or the above information, including a change of insurance policies.

Responsible party (or guardian) signature____Date______________________

AUTHORIZATION FOR CARE OF MINOR

I hereby authorize the Doctor of Woodbury Family Chiropractic to administer care as they so deem necessary to my son / daughter.

SIGNED ____________________________________ Date:______________________