BATES
CHIROPRACTIC & SPORTS THERAPY

Pediatric Chiropractic Intake Form - Ages 0-5 Years Old

Patient (Child) Information:

Name: _____ Date: _____

Address: _____

Sex: Male Female Date of Birth: _____ Height: _____ Weight: _____

Name(s) of Parents/Guardian: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email: _____ Would you like our newsletter emailed to you: Y N

How did you hear about our office? _____

Present Complaint: _____

When did this begin? _____ Was there an accident or injury involved? Y N

Has your child had any past treatment for this complaint? Y N Describe: _____

Current medications: _____

General Questions/Prenatal History:

Any complications during pregnancy? Y N Explain: _____

Medications taken during pregnancy: _____ Cigarettes or alcohol during pregnancy: Y N

Birth Intervention: Forceps Vacuum C-Section (emergency / planned) Induction Epidural

Complications during delivery? Y N Explain: _____

Genetic disorders or disabilities: _____

How many times has your child been prescribed antibiotics in the past 6 months? _____ Total during lifetime: _____

Has your child received vaccinations? Y N If yes, is it the full or graduated schedule?

Feeding History:

☐ Breast Fed; How long: _____

☐ Formula Fed; How long: _____

Introduced to:

Solids at _____ Months

Cows milk at _____ Months

☐ Food Allergies or Intolerances: ☐Y ☐N

List: _____

Childhood Diseases:

☐ Chicken Pox; Age _____

☐ Rubella; Age _____

☐ Mumps; Age _____

☐ Whooping Cough; Age _____

☐ Other: _____ Age _____

Developmental History:

During the following times your child's spine is the most vulnerable to stress and should routinely be checked by a doctor of chiropractic for prevention and early detection of vertebral subluxation (spinal nerve interference). At what age was your child able to:

_____ Respond to Sound

_____ Respond to Visual Stimuli

_____ Hold Head Up Alone

_____ Sit Up Alone

_____ Cross Crawl

_____ Pulls up on Furniture

_____ Stand Alone

_____ Walk Alone

According to the National Safety Council, approximately 50% of children fall head first from a high place during their first year of life (ie: a bed, changing table, down stairs, etc). Was this the case with your child? Y N

Explain: _____

Is/has your child been involved in any high impact or contact type of sports (ie: soccer, football, gymnastics, baseball, cheerleading, martial arts, etc)? Y N

Has your child ever been involved in a car accident? Y N Explain:_____

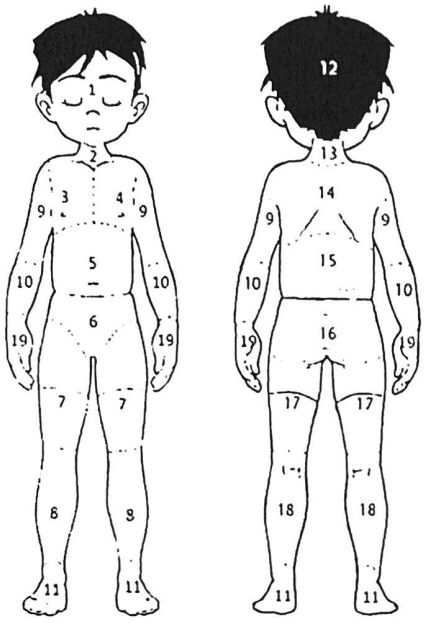
Other traumas not described above? Y N Explain:_____

Prior surgeries? Y N Explain:_____

DIET: How would you rate your child's diet? ☐Well Balanced ☐Average ☐High sugar/processed foods

SLEEP: Number of hours your child sleeps: _____ hours per night _____hours per day/naps

Sleep Quality: ☐Good ☐Fair ☐Poor



1 – face
2 – neck
3 – left chest
4 – right chest
5 – stomach
6 – abdomen
7 – thighs
8 – legs
9 – upper arms
10 – lower arms
11 – feet
12 – back of head
13 – back of neck
14 – upper back
15 – middle back
16 – lower back
17 – back thighs
18 – back legs
19 – hands

Imagine this picture is your body. Can you color the area that is hurting you right now?

Review of Systems

Please check if your child has had any of the following:

☐ Headaches	☐Ear Infections	☐ADD/ADHD
☐ Postural Imbalances	☐Seizures	☐Frequent Fever
☐ Growing Pains	☐Tonsillitis	☐Colic
☐ Scoliosis	☐Sleep Problems	☐Learning Difficulties
☐ Sensory Processing	☐Constipation	☐Acid Reflux
☐ Asthma	☐Bedwetting	☐Hip Dysplasia
☐ Torticollis	☐Autism	☐Allergies

Informed consent:

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 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, whatever he/she is suffering from - a latent pathological defect, illnesses or deformities - which would otherwise not come to the attention of the chiropractic physician.

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Authorization to Treat a Minor

I, _____ the undersigning parent/guardian having legal custody/ guardianship of _____, a minor, do hereby authorize Bates Chiropractic and its Doctors to perform in judgment, any examination and chiropractic treatment, which is deemed necessary.

I clearly understand and agree that I am personally responsible for payment of all fees charged by this office. Any and all x-rays remain property of the clinic as part of patient's permanent record.

ACKNOWLEDGMENT

I have reviewed the notice of privacy practices (HIPPA) and have been provided an opportunity to discuss my right to privacy. Upon request I will be given a copy.

COMMUNICATION

May we leave messages on any answering device, i.e. home answering machines or voicemails? ☐Yes ☐ N

MISSED APPOINTMENTS

There is a possible $25 fee charged for all appointments that are not cancelled prior to scheduled visit.

Any specific written authorization you provide may be revoked at any time by writing to us at the above address.

Patient: _____ _____ _____

Print Name Signature: Parent/Legal Guardian Date

Doctor: _____ _____

Date

Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of your Protected Health Information

Your Protected Health Information will be used by Bates Chiropractic or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. You may review the Notice prior to signing this consent. You may request a copy of the Notice at the Front Desk.

Requesting a Restriction on the Use or Disclosure of Your Information

Your may request a restriction on the use or disclosure of your Protected Health Information.
This office may or may not agree to restrict the use or disclosure of your Protected Health Information.
If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

Reservation of Right to Change Privacy Practice

This office reserves the right to modify the privacy practices outlined in the Notice.

Signature

I have reviewed this consent form and give my permission to this office to use and disclose my health information in accordance with it.

_____

Name of Patient (Print)

_____

Signature of Patient Date

_____

Signature of Patient Representative

_____

Relationship of Patient Representative to Patient

_____

Office Representative Date