CHILD INTAKE FORM

PERSONAL INFORMATION

Child's First Name:_____ Child's M.I.:_____ Child's Last Name:_____

Child's Preferred Name:_____

Child's Age:_____ Child's Birthday:_____

Child's Gender:_____

Parent/ Legal Guardian's Name:_____

Spouse's Name:_____

Address:_____ City / State / Zip:_____

Cell Phone: ( )_____ Alternate Phone: ( )_____

Text Reminders: Y N Before Appointment: 1 hr 4 hrs 1 day

Email:_____ (For EMAIL reminders, events, etc)

Who can we thank for referring you or how did you hear about IHH Family Chiropractic?

_____

REASON FOR SEEKING CARE

What concerns do you feel IHH Family Chiropractic can address for your child?_____

_____

Related to: ☐Accident (Fall, Sports, Auto) ☐Birth ☐Chronic ☐Other _____

Please describe how these concerns are affecting your child's quality of life. _____

_____

Check all that apply:

☐School ☐Exercise/Sports ☐Walking ☐Playing

☐Sleep ☐Attention/Focus ☐Communication ☐Eating

☐Daily Routine

EXPECTATIONS OF CARE

I would like my child to experience the following benefits from Chiropractic Care:

Check all that apply:

- ☐ Symptomatic relief of pain or discomfort
- ☐ Correction of the cause of the problem as well as relief of symptoms
- ☐ Prevention of future problems
- ☐ Healthier spine and nervous system
- ☐ Optimal health on all levels
- ☐ OTHER_____

HEALTH, WELLNESS, AND CHIROPRATIC CARE

The primary system in the body which coordinates health is the NERVOUS SYSTEM.
The vertebrae (bones of the spinal column) surround and protect the delicate NERVOUS SYSTEM.
Injury to the SPINE and NERVOUS SYSTEM is a condition called VERTEBRAL SUBLUXATION.
VERTEBRAL SUBLUXATION results in nerve malfunction due to vertebral/spinal misalignment.

Vertebral Subluxations can have Physical, Emotional and Chemical causes and effects.

The information below will help us to see the types of PHYSICAL, EMOTIONAL & CHEMICAL stresses your child has been subjected to, how they may relate to his/her present spinal, nerve and health status and whether they may have caused Vertebral Subluxations to occur.

PREGNANCY & BIRTH

During pregnancy, did the mother:

☐ Experience any significant illnesses, difficulties, or trauma? _____

☐ Take any drugs/medications?_____

☐ Smoke or consume alcohol?_____

☐ Home birth ☐ Hospital birth ☐ Vaginal ☐ Water birth ☐ Caesarean

Was the delivery premature? ☐ No ☐ Yes Weeks _____Weight _____

Approximately how long did labor last? _____ hours

Was labor artificially induced? ☐ No ☐ Yes _____

Was it determined that the child was breech or otherwise malpositioned? ☐ No ☐ Yes, how? _____

The birth process can be traumatic to a baby's spine and cause interference to the nervous system. Please check which, if any, of the following were administered during labor and birth.

☐ Epidural ☐ Forceps ☐ Vacuum ☐ Medications _____

☐ Pitocin ☐ Episiotomy ☐ Manual traction of the neck

Please check all that apply to the baby's status immediately after birth:

☐ Jaundice ☐ Respiratory Issues ☐ Broken bones_____

☐ Feeding problem ☐ Hypo/hypertonia ☐ Other conditions _____

APGAR Score _____

Is/was the baby breastfed? ☐No ☐Yes, for how long?_____

CHEMICAL STRESS

Chemical stresses can occur when a substance that is toxic to the body is breathed, injected, taken by mouth, or comes into contact with the skin. The following will reveal exposures your child may have experienced.

Please check all vaccinations the child has received and at what age they were administered:

☐ DPT _____ ☐ MMR _____ ☐ Other _____

☐ Polio _____ ☐ Chicken Pox _____ ☐ Hepatitis _____

☐ Flu _____

Please describe any and all reactions to vaccine(s)_____

Please check all that apply and give any necessary details:

☐ Child exposed to second-hand smoke_____

☐ Has taken antibiotics _____

☐ Currently taking medication _____

☐ Currently taking supplements _____

☐ Has allergies _____

What treatments have you used? _____

PHYSICAL STRESS: INFANCY & CHILDHOOD

Please check all that apply to your child and give any necessary details:

☐ Uncoordinated/ Several Falls?_____

☐ Has been hospitalized/ surgery_____

☐ Had a severe trauma_____

☐ Been in an automobile accident_____

☐ Has fractured a bone or dislocated a joint_____

☐ Has/had a chronic illness_____

☐ Hypotonia/Hypertonia?_____

What physical activities does your child participate in (if any)?_____

EMOTIONAL STRESS

It is difficult to separate the emotional stress in our life from the physical response that often occurs. Please indicate if your child has ever or is currently experiencing any of the emotional stresses below (If your child is more than a year old):

☐ Academic pressure	☐ Loss of a loved one	☐ Bullying	☐ Relocation
☐ Lifestyle change	☐ Parents' divorce	☐ Loss of a pet	☐ New sibling

Does your child have difficulty interacting with schoolmates or friends? ☐ Yes ☐ No

Have you or anyone else noticed that your child is nervous, twitches, shakes, or exhibits rocking behavior? ☐ Yes ☐ No

HEALTH CARE PRACTITIONER HISTORY

Has your child ever received chiropractic care? ☐Y ☐N Name of D.C. _____

Reason _____ How long? _____ Date of last visit _____

Why was care stopped? _____

Have you consulted or do you regularly consult any of the following providers for your child?

Check all that apply	☐ Medical Physician	☐ Naturopath	☐ Acupuncturist	☐ Neurologist
	☐ Massage Therapist	☐ Psychotherapist	☐ Physical Therapist	☐ Other

Reason _____

_____

HIPAA POLICY

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to define situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment, or practice operations will be made only after obtaining your consent. You may request restrictions on your disclosures. You may inspect and receive copies of your records within 30 days with a request. You may request to view charges to your records. In the future, we may contact you for appointment reminders, announcements, and to inform you about our practice and its staff.

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain righ ts to privacy regarding my protected health information. I understand that this information can and will be used to conduct, plan, and direct my treatment and follow-up with multiple healthcare providers who may be involved in that treatment directly or indirectly, obtain payment from third-party payers, and conduct normal healthcare operations such as quality assessments and physician's certificates. I have read and understand your Notice of Privacy Practices. I also understand that I can request in writing that you restrict how my personal information is used and disclosed.

Date:_____ Print Patient Name:_____ Signature: _____

FINANCIAL POLICY

Our goal is to provide the highest quality of healthcare possible for our patients. In order to achieve this goal, we need your commitment as well.

- Payment for services is due upon receipt.
- We urge our patients to follow the doctors' recommendations for care. Please keep your appointments as scheduled or call our office within 24 hours to make any changes. In order to attain the level of achievement we both desire, care must be followed.
- I authorize IHH Family Chiropractic to release any information deemed appropriate concerning my physical condition to any insurance company, attorney, or adjuster in order to process any claim for reimbursement charges incurred by me.
- Chiropractic care in this office deals with vertebral subluxation, and will, therefore, be billed according to diagnostically appropriate procedural codes. While we will provide an itemized receipt upon your request, we anticipate that care will not be reimbursed by a third party carrier. This does not apply to PI, WSI, or Medicare. HSA and FLEX spending accounts may be utilized.
- I authorize the direct payment to IHH Family Chiropractic of any sum I now or hereafter owe by my attorney out of a settlement of my case, and by any insurance company obligated to make payment to me or IHH Family Chiropractic based in whole or in part upon the charges made for services received. I hereby appoint IHH Family Chiropractic authority to endorse and cash checks, drafts, or money orders made payable to the undersigned or as co-payee with this clinic or payments due for services rendered on behalf of the undersigned by IHH Family Chiropractic.
- If you have any questions about our financial policies, please ask our staff. If you need to make special arrangements, please ask. We will do everything possible to meet your financial needs.
- Advanced Beneficiary Notice of NON-Coverage (ABN). Your health insurance does not pay for everything, even some care that you or your healthcare provider have good reason to think you need. We expect your health insurance will not pay for items and services such as your initial visit and any chiropractic care deemed maintenance or wellness care by your carrier (as well as other items that may arise in the future). Signing below signifies that you want these items and services, but understand that they will not be billed to your insurance company. Therefore, you are responsible for payment and cannot appeal to your insurance carrier as they were not submitted and/or billed to them. This notice gives our opinion, not an official Medicare or other insurance carrier's decision. If you have other questions, please ask our staff. Signing below means that you have received and understand this notice.

Date:_____ Signature: _____

AUTHORIZATION FOR CARE

I hereby authorize the doctors and staff at IHH Family Chiropractic to adjust my spine as deemed appropriate. At IHH Family Chiropractic, we do not diagnose or treat any disease or condition other than vertebral subluxation and the doctors/clinic will not be held responsible for any pre-existing medical conditions. I certify that the above information is correct to the best of my knowledge. I will not hold the doctors or any staff member of IHH Family Chiropractic responsible for any errors or omissions that I may have made in the completion of this form. Chiropractic, as well as all other types of health care, is associated with potential risks in the delivery of treatment. While chiropractic treatment is remarkably safe, you need to be informed about the potential risks related to your care to allow you to be fully informed before consenting to treatment. Please inquire if you have further questions. Chiropractic is a system of healthcare delivery and therefore, as with any health care delivery system, we cannot promise a cure for any symptom, condition, or disease as a result of treatment in this office. An attempt to provide you with the very best care is our goal, and if the results are not acceptable, we will refer you to another provider who we feel can further assist you.

Date:_____ Signature: _____

ADVANCED BENEFICIARY NOTICE (ABN)

The purpose of this form is to help you be aware of chiropractic services in this office as it relates to any medical insurance you may have. Chiropractic care in this office is not focused on the diagnosis of or relief of symptoms; it is centered on the location, analysis, and correction of underlying vertebral subluxations. Because of this, all services are coded in a manner which insurance carriers view as maintenance or wellness care and most likely will not be covered. Signing below signifies that you want the services provided in this office, but understand that they will not be billed to your insurance company. Therefore, you are responsible for payment and cannot appeal to your insurance carrier as they were not submitted and/or billed to them. This notice gives our opinion and policies as it relates to insurance coverage, not an official Medicare or other insurance carrier's stance or decision. Signing below indicates you have received and understand this notice.

Date:_____

Name (Printed): _____

Signature: _____

Parent/Guardian Signature (if aplicable):_____