

PEDIATRIC CHIROPRACTIC INTAKE FORM

• Today's Date:_____ Name of Child:
 Date of Birth: • Gender:

Male
Female • Name of Parent/Guardian:______ • Phone:_____ • Address:_____ • City:_____ • State:___ • Zip:____ • Email:______• Text Reminders: \square Yes \square No Siblings, Name & Ages: Reason for today's visit? Any health concerns? • Has your child undergone care for any conditions? (please list medications):_____ Birth Information • Birth Location: ☐ Home Birth ☐ Birth Center ☐ Hospital Birth Provider: □ Midwife □ OBGYN Duration of pregnancy: ___ weeks • Induced labor: □ Yes □ No • Vacuum: ☐ Yes ☐ No • Forceps: □ Yes □ No • Birth Weight: _____ • Length: ____ • Duration of Labor/active labor: ____ • APGAR: ___ • Any medications during labor/delivery?____ If so, what kind:_____ • Was baby alert and responsive within 12 hours of birth? ____If no, please explain:_____ • Do sleeping patterns seem normal to you? _____If no, please explain:_____ How many wet diapers in a day? ____ How many dirty diapers in a day? ____ • What is baby's diet like? (Breastfeeding times, oz of milk, formula, solids, etc.)_____



SPORTS & PHYSICAL ACTIVITY

PEDIATRIC CHIROPRACTIC INTAKE FORM - CONTINUED

Sports played and years began:
• Hours per week:
Weight of school backpack:
○ CHIROPRACTIC HISTORY
• Has your child ever seen a Chiropractor? □ Yes □ No
Name of Chiropractor:
◎ MILESTONES (Check all those that apply)
1–3 MONTHS:
O Supports head and upper body when on stomach
O Stretches out legs and kicks when on back or stomach
Opens and shuts hands
Grabs and shakes toys
Follows moving objects with eyes
Turns head to sound of stimulus
Makes cooing sounds
Smiles at familiar faces
4–7 MONTHS:
Rolls over both stomach to back & back to stomach
Sits up with/without support
Reaches for objects
Transfers objects from hand to hand
Supports whole weight standing
Explores objects with hands and mouth
Laughs
Babbles consonants
8–12 MONTHS:
Gets in and out of sitting position independently
Gets on hands and knees position to crawl
Pulls self up to standing / walks along furniture
Holding spoon or book by themselves
Says "mama" and "dada" referring to parent



SINCE THE HEALTH OF THE NERVOUS SYSTEM CAN BE AFFECTED BY MANY TYPES OF STRESSORS, THE FOLLOWING INFORMATION IS VERY IMPORTANT.

CHEMICAL STRESSORS (Child's age may not apply to parts of this section)
• Was baby breastfed? \square Yes \square No • For how long?
• Was formula ever introduced? \square Yes \square No • What age/type of formula?
• Was there introduction of cow's milk? \square Yes \square No • What age?
• Food/Juice intolerance? \square Yes \square No • If Yes, what type?
• Did mother smoke during pregnancy? □ Yes □ No
• Did mother drink alcohol? □ Yes □ No
• Any illness of mother during pregnancy? □ Yes □ No
• Any drugs taken during pregnancy? □ Yes □ No
• Any invasive procedures (amniocentesis, CVS)? □ Yes □ No
• Was baby vaccinated at birth? \square Yes \square No • If yes, which ones?
• Any reactions to vaccines? \square Yes \square No • If yes, what kind?
• Any antibiotics since birth? \square Yes \square No • If yes, what kind?
PSYCHOSOCIAL STRESSORS (Child's age may not apply to parts of this section)
• Any difficulties with nursing? \square Yes \square No \square If yes, what kind?
• Any behavioral problems? \square Yes \square No \square If yes, what kind?
• Any night terrors, sleepwalking, bed wetting? \square Yes \square No • Explain:
* TRAUMATIC STRESSORS (Child's age may not apply to parts of this section)
• Any traumas during pregnancy (falls/accidents)? \square Yes \square No • If yes, what kind?
• Any birth trauma evidence? (e.g., bruises, odd shaped head, stuck in birth canal, excessively long birth, respiratory
depression, cord around neck, other) \square Yes \square No • If yes, what kind?
• Any falls from couches, bed, changing tables? 🗆 Yes 🗆 No • If yes, what kind?
• Any hospitalizations? \square Yes \square No • If yes, please explain:
• Any surgeries? \square Yes \square No \square • If yes, please explain:



PATIENT HIPPA CONSENT FORM

Protecting the privacy of your child's personal health information is important to us. Disclosure of your child's 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. 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 rights and 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. I have read and understand your Notice of Privacy Practices. A more complete description can be requested. I also understand that I can request, in writing, that you restrict how my personal information is used and disclosed.

Date:	Print Patient Name:
Guardian Signature:	Relationship to Patient:

FINANCIAL POLICY & AUTHORIZATION FOR CARD

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

- We urge our patients to follow the doctor's 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.
- Cove Freedom Chiropractic does not submit to insurance. Understand that you are responsible for payments for care at time of service or in advance. Upon request, you can receive a superbill to submit to your insurance for reimbursement.
- If you have any questions about our financial policies, please ask. 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 reimburse for everything, even some care that you or your health care 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 as maintenance or wellness care by your carrier. 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. Signing below means that you have received and understand this notice.

Date:	Guardian Signature:
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I hereby authorize doctors and staff at **Cove Fredom Chiropractic** to provide care as deemed appropriate. At **Cove Freedom Chiropractic**, we do not diagnose or treat any disease or condition other than vertebral subluxation and the doctor/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 doctor 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 health care 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:	Guardian Signature:
Brain Spain	