Pediatric Intake & History—1

Patient Name: _____ Date: _____ DOB: _____

PATIENT INFORMATION

Address _____

City, State, Zip _____

Phone (H) _____

Phone (C) _____

Email _____

q Male q Female Age _____ Birthday _____

IN CASE OF EMERGENCY, CONTACT

Name _____

Relationship _____

Contact Number _____

Mother's Name _____

Mother's DOB _____

Mother's Occupation _____

Mother's Phone _____

Mother's Email _____

Father's Name _____

Father's DOB _____

Father's Occupation _____

Father's Phone _____

Father's Email _____

Who may we thank for referring you? _____

HOW CAN WE HELP YOUR CHILD?

q Wellness Checkup q Other _____

_____

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

_____

_____

Has your child been treated on an emergency basis? q No q Yes Please describe _____

_____

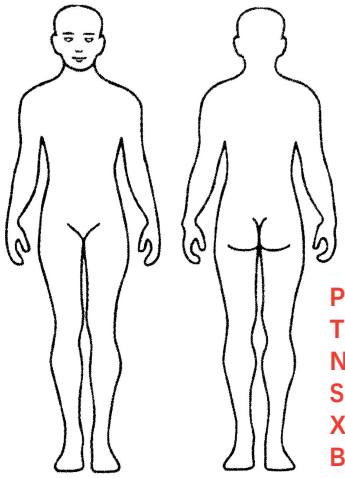
_____

What are your goals for care: _____

_____

_____

_____



P–Pain
T–Tender
N–Numb
S–Spasm
X–Shooting
B–Burning

PREGNANCY HISTORY

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

q Back/Other Pain q Gestational Diabetes q Pre/Eclampsia q Strep B q Fatigue

q Pre-Term q Nausea/Vomitting q Swelling q Other _____

q 3rd Trimester Presentation: q Vertex q Breech q Transverse q Face/Brow

BIRTH HISTORY

Type of birth (check all that apply)

q Hospital q Birth Center q Home q Normal/Vaginal q Breech q Cesarean q Scheduled/Induced

q Epidural q Forceps q Sunction Cup or Vacuum

Problems during labor/delivery? _____

_____

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

q Respiratory Distress q Extended Hospitalization q Sunction Cup or Vacuum q Other _____

Pediatric Intake & History—2

Patient Name: _____ Date: _____ DOB: _____

GROWTH & DEVELOPMENT

Infant feeding (provide length of time)

q Breast: weeks _____ months _____ q Bottle: weeks _____ months _____ q Formula: weeks _____ months _____

Number of hours of sleep each night _____ Quality of sleep q Good q Fair q Poor

At what age did the child: Respond to sound _____ Crawl _____ Hold head up _____

Stand _____ Sit unsupported _____ Walk unsupported _____

CHILDHOOD DISEASES, ILLNESSES & VACCINATIONS

Indicate if your child has had any of the following diseases (check all that apply)

q Chicken Pox q Measles q Rubeola q Mumps q Rubella q Pertussis/Whooping Cough

Indicate if you r child has ever suffered from any of the following (check all that apply)

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

ALLERGIES, MEDICATIONS, SURGERIES & FAMILY HISTORY

ALLERGIES (list) _____ MEDICATIONS (list) _____

SURGERIES (list) _____ FAMILY HISTORY (list) _____

Obstetrician/Midwife _____

Pediatrician/Family MD _____

Date of Last Visit _____ Purpose _____

Vaccination History _____

Number of doses of antibiotcs your child has taken: During the past six months _____ During his/her lifetime _____

Previous Chiropractor _____

Date of Last Visit _____ Purpose _____

Has your child ever been treated on an emergency basis? _____ If yes, please explain: _____

Purpose of this appointment _____

Insurance/billing information _____ Policy # _____

AUTHORIZATION FOR CARE OF MINOR

Signed _____ Witnessed _____ Date _____

I hereby authorize this office and its doctor(s) to administer care as they so deem necessary to my son/daughter/ward (upon approval of parent or guardian). I realize that I am responsible for all fees charged by this office and I agree to pay for all services provided.

Signed _____ Date _____

FAMILY FIRST CHIROPRACTIC
We Care

Patient Name: _____ D.O.B.:_____ Date:_____

Financial Policies

Proof of Insurance: New patients must complete our new patient information forms before seeing a doctor. We must obtain a copy of your picture ID and current insurance card to have proof of insurance. If you do not provide us with the correct insurance information in a timely manner, you will be responsible for any balance accrued. If your insurance lapses or expires we require full payment within 10 days unless you provide proof of valid insurance coverage.

❑ Self-Pay: Patients without health coverage are expected to make payment in full at the time services are rendered. Any Plan Discounts can only be applied to services paid at the time the services/plans are rendered/initiated. A service charge of 15.00% per annum may be applied to all unpaid balances over sixty days. Financial Hardship is only available upon proof of said hardship and exclusively at the discretion of the doctor.

❑ Medicare: Deductible and/or Co-Insurance is due at time of service when no secondary insurance coverage is available, or benefits cannot be verified. Services not statutorily covered by the Medicare Program are due at the time services are rendered. An Advance Beneficiary Notice will be required for all services not covered or not believed to be covered. Deductibles will be billed and shall be due within ten days. A service charge of 15.00% per annum may be applied to all unpaid balances over sixty days.

In-network plans: I understand Family First Chiropractic will submit claims on by behalf and prepare any necessary reports and forms to assist me in making collection from the insurance company. Family First Chiropractic will accept direct assignment of benefits under this policy and will credit any payments received from insurance company to your account.

I have read and understand the above Financial Policy fully understand that I am ultimately responsible for payment of all services and any costs associated with the collections including but not limited to service charges and other fees for any balance due at to the above office and doctor.

_____ _____
Signature of patient or authorized representative Date

_____ _____
Authorized Representative Name Printed Relationship to Patient

FAMILY FIRST CHIROPRACTIC
We Care

Electronic Health Records Intake Form

In compliance with requirements for the government EHR incentive program

First Name: _____Last Name: _____

Preferred Language: _____ D.O.B.___/____/_____ Sex: _____

Sex at Birth:_____

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

CMS requires providers to report both race and ethnicity If yes, start date:_____

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) Native Hawaiian or Pacific Islander / Other / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

☐ I choose to decline receipt of my clinical summary after every visit.

Patient Signature:_____ Date: _____

For office use only

Height: _____ Weight: _____ Blood Pressure: _____/_____ Pulse:_____

FAMILY FIRST CHIROPRACTIC
We Care

Patient Name: _____ DOB: _____ Date: _____

Consent for Care

The process of determining suitability of Chiropractic Services involves answering fully and truthfully all questions presented to you either written or spoken regarding your past and present health conditions during the Consultation.

If warranted, a physical examination will be performed that can include but is not limited to: vitals measurement, systems evaluation, orthopedic tests and maneuvers (tests that move and stress joints of the body), neurological test (tests using sharp or dull instruments, smells or sounds, gently tapping tendons) as well as physical touching. These test and maneuvers will help the Chiropractor determine what may be causing your complaints. Occasionally some temporary soreness and/or stiffness may occur due to the examination; less frequently aggravation of presenting symptoms or initiation of new symptoms.

Radiographs (X Rays) may be taken or ordered to further the Chiropractor's understanding of the underlying condition, positions and alignment of the spine and associated structures. There is limited but present risk to radiation exposure. If you are or think you may be pregnant alert the Chiropractor and/or X ray lab technician; X Rays are not allowed to pregnant women in any trimester.

Privacy Notice Acknowledgment

We are concerned with protecting your privacy, especially in matters that concern your personal health information. In accordance with the *Health Insurance Portability and Accountability Act* of 1996 (HIPAA), we are required to supply you with a copy of our privacy policies and procedures. We encourage you to read this document carefully, for it outlines the use and limitations of the disclosure of your health information and your rights as a patient. If you ever have any questions or concerns regarding the use or dissemination of your personal health information, we would be happy to address them.

I consent to the performance of the above-mentioned procedures performed by the doctor involved in my case: ____ YES _____ NO

I acknowledge that I have been offered a copy of Family First Chiropractic's *Notice of Privacy Practices for Protected Health Information.*

Patient Signature: _____ Date:_____

Witness Signature: _____Date:_____