Pediatric Intake

Child's Name: First_______________________Middle____________________Last____________________________

Guardian's Name (s): ____

Address:____________________________________ City: ___________________ State: _______ Zip:_______

DOB: __/_____/_____ Age: _____________ Nickname:________________ Number of Siblings: ______________

Guardian's Cell: __________________ Alternative:_______________ Referred By:_______________________

Guardian's Employer: ____________________________ Name of Insured: ____________________________

Emergency Contact: _____________________________ Phone: _______________________________________

Federal guidelines require the following: **Gender**: Male Female **Height :**__ft _____in **Weight:**_________lbs.

Language: English Other ____________________ **Does patient smoke?** No Yes

Race: Caucasian African American Native American Asian Other_______________ **Ethnicity**: Non-Latino Latino

Payment Options

________ **Cash** (When paid in full on same date as service, a same day discount will apply.)

________**Major Medical with Assignment** (Acu-Chiropractic will take assignment for your chiropractic benefits. All uncovered expenses, including co-payments, are to be paid at the time of service.) Primary___________________Secondary___________________

________**Medicare** (Medicare covered 80%, after your deductible has been met.)

________**Workers' Compensation** (WC is covered at 100% of the Minnesota mandated amounts. Patients are not responsible for any charges from a workers compensation claim.)

________ **Auto Insurance with Assignment** (Acu-Chiropractic will take assignment for your chiropractic benefits. All uncovered expenses, including co-payments, are to be paid at the time of service.)

________**Secondary Insurance** (Acu-Chiropractic will submit to your secondary insurance after we have received your explanation of benefits from your primary insurance company.

________(initial) I understand that if I choose to have my child receive the treatment described below, I will be billed the chiropractor's usual fee and I will be personally responsible for payment of any and all changes associated with this treatment.

Infant or Pediatric Care, not covered by insurance: $30

Cranial Work: $30 Cranial Work with Chiropractic: $50 Graston: $30 Kinesiotaping: $5 Acupuncture: $25

HIPPA (Federal Law) and Acu-Chiropractic Policies

- If you are unable to keep your appointment, please notify the office 24 hours before your scheduled time. Acu-Chiropractic reserves the right to charge the individual directly for missed appointments. (initial) _______
- I have read and understand the contents of the following:
  - ◊ Notice of Privacy Practices and Patient Consent Form: (initial) __________
  - ◊ Acupuncture and Massage Therapy Informed Consent: (initial) __________
- Acu-Chiropractic reserves the right to charge a fee for returned checks.
- Acu-Chiropractic will charge a 1.25% monthly interest fee for accounts over 90 days past due. The patient will be responsible for all fees if the account is sent to a collection agency.

Patient/Guardian's Signature: ____ Date: ____________________

BP: / Pulse: **Pediatric History** Name: ____________________

Primary concern: ____________________ **When did it start:** ____________________

Does your child complain of:

Neck pain | Mid back pain | Low back pain | Stomach Pain | Ear Infections

Arm pain | Leg pain | Headaches | Other ____________________

Which side (s): Right Left Both **Pain Intensity:** no pain (0/10) mild pain (1-3/10) moderate pain (4-7/10) intense pain (8-10/10)

Quality of discomfort: pain sore achy shooting burning dull **Home Care:** ice heat pain medication massage Other ____________________

What makes it better: Ice Heat Massage Rest Activity Other ____________________ **Makes it worse:** ____________________

Any history of:

Asthma	Allergies	Ear infections	Interrupted Sleep
Upper respiratory infections	Indigestion	Colic	Vomiting
Childhood illnesses (chicken pox, etc.)	Bed wetting	Fussiness	Rashes

Typical Diet:

Breakfast ____________________

Lunch ____________________

Dinner ____________________

Sensitive to milk or gluten? ____________________

Health History

Primary Care Physician and Clinic: ____________________

Do you have any general concerns for your child (behavior, sleep disturbance, clumsiness): ____________________

List medications or supplements your child is taking and dosage: ____________________

Allergies (medication and environmental): ____________________

What vaccinations has your child had: ____________________ When was the most recent vaccination: ____________________

Hospitalizations/Surgeries: ____________________

Accidents/Injury: ____________________

Illness: ____________________

Fractures: ____________________

When was their first ear infection: __________ Since then, how frequent are ear infections: __________ Which ear: __________

Family History (cancer, diabetes, etc.) : ____________________ Any smokers in home: Yes No

Child:

What activities are your child involved in: ____________________

Has your child had a recent growth spurt or growing pains? ____________________

Difficulty concentrating or focusing ? ____________________

Has your child had any recent falls (down the stairs or from greater than 3 feet)? **No** **Yes, explain:** ____________________

Trauma

How did the injury occur: ____________________

Onset: Sudden Gradual **Progression:** Constant Intermittent **Getting:** Better Same Worse

History of same injury: Yes No **When:** ____________________

Where does it hurt: ____________________

When did the injury occur: ____________________

INFANTS ONLY: Birth History

How long was labor: __________ **APGAR score:** __________ **Birth Weight:** __________

Any complications: ____________________

Any of the following: Breech Forceps Vacuum C-Section Induction Fetal Distress

Any difficulties with home life transition: ____________________

Is baby being breast fed: Yes No **Any feeding difficulties:** ____________________

Does baby frequently arch neck or head: ____________________