Pediatric Intake

Child's Name: First_____Middle_____Last_____

Guardian's Name (s): _____

Address:_____ City: _____ State: _____ Zip:_____

DOB: ___/_____/_____ Age: _____ Nickname:_____ Guardian's Cell: _____

Guardian's Email: _____ **Referred By**:_____

Guardian's Employer: _____ Name of Insured: _____

Emergency Contact: _____ Phone: _____

Gender: Male Female **Height :**___ft ___in **Weight:**_____lbs. **Number of Siblings**: _____

Spoken Language at Home: English Other _____

Pediatrician Provider/Facility: _____ **Location:** _____

Payment Options

_____ **Cash** When paid in full on same date as service. *No Insurance* New Patient Exam $135. Follow up visit(s) $40

_____**Major Medical Insurance** (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_____

_____**Auto Insurance** (Motor vehicle accidental insurance, open claim.)

_____(**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. Some services are not covered by insurance.

Cranial Work: $30 Cranial Work with Chiropractic: $65 Kinesiotaping: $8 Acupuncture: $35

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 | Vision loss

Childhood illnesses (chicken pox, etc.) | Bed wetting | Fussiness | Rashes | Dizziness

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: _____