

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: _____ Insured Holder Name: _____

Emergency Contact: _____ Phone: _____

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

Spoken Language at Home: English Other _____

Is there someone you would like medical information shared with? _____

Payment Options

_____ **Cash** When paid in full on same date as service. *No Insurance* New Patient Exam \$135. Follow up visit(s) \$35

_____ **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 charges associated with this treatment. Some services are not covered by insurance.

Cranial Work: \$40 Cranial Work with Chiropractic: \$65 Kinesiotaping: \$10 Acupuncture: \$40

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/Graston/Cupping/Laser 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: _____