

Pediatric New Practice Member Intake Form

First Name: _____
Last Name: _____
Nickname: _____
Age: _____ Date of Birth: _____
Sex: () Male () Female
Height: _____ Weight: _____
Social Security #: _____
Home Phone: _____
Work Phone: _____
Cell Phone: _____
Address: _____
City: _____
State: _____ Zip Code: _____

Mothers Name: _____
Fathers Name: _____
Pediatrician's Name: _____
Insurance: () Work Comp () Auto () MA
() Medicare () Private: _____
Whom may we thank for referring you to our office? _____
How were you referred to our office?
() Yellow pages () Lecture () Drive by
() Coupon () Screening = Where? _____

() Mailing = which one? _____
() Other: _____

Your Child's Health Profile

Please rate the overall health status of your child:

Poor 1 2 3 4 5 6 7 8 9 10 Excellent

What are your health objectives for your child? _____

Name/Address/Phone of the last doctor who put your child on a health development program: _____

Were you able to keep your child on that program? **Y N** How long? _____

What were the results? _____

Describe your child's health trend? **Better Worse Same Not Sure**

If better, what did you do to improve your child's health? _____

If worse, why do you think your child's health declined? _____

Will your child be healthier 5 years from now than they are today? **Y N Not Sure**

If so, what are you planning to do to improve your child's health and if not, what could you do to improve their health rather than have it continue to decline? _____

After making these changes in your child's life, how do you expect their health to be 5 years from now? _____

Has your child had previous chiropractic care? **Y N**
If yes, what was the doctor's name? _____

What was the approximate date of the last visit? _____

What was the duration of their care? _____

Were you aware that:

- Doctors of Chiropractic work with the nervous system? **Yes** **No**
- The nervous system controls all bodily functions and systems? **Yes** **No**
- Chiropractic is the largest natural healing profession in this world? **Yes** **No**
- If Chiropractic care starts at birth, you can achieve a higher level of health throughout life? **Yes** **No**

What other wellness professionals are currently parts of your child's health care team?

- Massage Therapist** **Acupuncturist** **Naturopath** **Homeopath**
 Other: _____

How many Medical Doctor's office visits did your child have last year?

- None** **Less than 5** **More than 5** **More than 10**

Is your current condition the result of a recent: **auto accident?** **work related injury**

What was the date of injury? _____

**If so, please inform the front desk staff immediately to obtain additional necessary paperwork.*

Please describe below, in the following 2 sections, your primary, secondary and additional reasons, if any, for seeking care in our office:

Primary Complaint (List one only): _____

When did your child first experience this problem? _____

How did this problem first begin? _____

How often does your child experience this problem? **1-2x/week** **3-4x/week** **5-6x/week** **daily**

other: _____

Please grade the intensity of this problem (with 10 being worst):

At best 1 2 3 4 5 6 7 8 9 10

At worst 1 2 3 4 5 6 7 8 9 10

How does your child describe the symptoms (i.e. burning, stabbing, aching, sharp, etc.)? _____

Please describe the location of the pain: _____

Does this problem cause pain to travel to any other area? **Y N**

If yes, where? _____

Is this problem getting: **worse?** **better?** **staying the same?**

What seems to aggravate this problem? _____

What have you tried to relieve this problem (i.e. interventions, treatments, aspirin, medications, surgery)? _____

Have you seen any other doctors for this problem? **Y N** If yes, who? _____

What treatment was given? _____

How effective was the care? _____

Secondary Complaint -- if any (List one only): _____

When did your child first experience this problem? _____

How did this problem first begin? _____

How often does your child experience this problem? () **1-2x/week** () **3-4x/week** () **5-6x/week** () **daily**
() **other:** _____

Please grade the intensity of this problem (with 10 being worse):

At best 1 2 3 4 5 6 7 8 9 10

At worst 1 2 3 4 5 6 7 8 9 10

How does your child describe the symptoms (i.e. burning, stabbing, aching, sharp, etc)? _____

Please describe the location of the pain: _____

Does this problem cause pain to travel to any other area? **Y N** If yes, where? _____

Is this problem getting: () **worse?** () **better?** () **staying the same?**

What seems to aggravate this problem? _____

What have you tried to relieve this problem (i.e. interventions, treatments, aspirin, medications, surgery)? _____

Have you seen any other doctors for this problem? **Y N** If yes, who? _____

What treatment was given? _____

How effective was the care? _____

Medical History

Prenatal History:

Name of Obstetrician or Midwife (please circle which one): _____

Location of Birth: **Hospital** **Birth Center** **Home**

Birth Interventions? **Forceps** **Vacuum extraction** **C-Section** **Epidural**

Complications during delivery? **Y N** If yes, what? _____

Birth Weight: _____ Birth Length: _____ APGAR Scores: ____ / ____

Complications during pregnancy? **Y N** List: _____

Ultrasounds during pregnancy? **Y N** How Many? _____

Medications during pregnancy? **Y N** List: _____

Rhogam shot? **Y N** Cigarette use during pregnancy? **Y N**

Alcohol use during pregnancy? **Y N**

Is your child vaccinated? **Y N** Vaccinations History (age of first vaccination, etc.): _____

Was your child breast fed? **Y N**

If yes, how long? _____

If no, what formula? _____ How Long? _____

At what age were solid foods introduced at? _____

At what age was cow's milk introduced at? _____

Does your child have any food or juice allergies? **Y** **N** If so, what: _____

Nutritional Supplements your child is currently taking: _____

Number of doses of Antibiotics your child has taken: _____ During the past 6 months: _____ Total: _____

Number of dose of other prescription medications your child has taken: _____ During the past 6 months: _____ Total: _____

Please check any of the following illnesses your child has had:

- | | | |
|--|---|---|
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Mumps | <input type="checkbox"/> Influenza |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Small Pox | <input type="checkbox"/> Pleurisy |
| <input type="checkbox"/> Polio | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Cancer | <input type="checkbox"/> Mental Disorders |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Lumbago |
| <input type="checkbox"/> Measles | <input type="checkbox"/> Thyroid Disorder | <input type="checkbox"/> Eczema |
| <input type="checkbox"/> Rubella | <input type="checkbox"/> Rubeola | <input type="checkbox"/> Whooping Cough |

Surgeries:

Date	Type	Reason for surgery
_____	_____	_____
_____	_____	_____
_____	_____	_____

Previous injuries or trauma (please give type and date): _____

Medications (including over the counter drugs):

Medication & Dosage	Reason for taking
_____	_____
_____	_____
_____	_____

Please list the cause of death and age of any immediate family members (parents or siblings):

Relationship	Cause of Death	Age of death
_____	_____	_____
_____	_____	_____

Lifestyle / Social History

Recreational Activities: _____

How much television (including video games) does your child watch per day? _____

Does your child drink water? **Y** **N** If yes, how much? _____

How often does your child exercise or participate in strenuous activities/play?

- () **daily** () **x/week** () **occasionally** () **never**

How many hours of sleep does your child get on average? _____

Is your child involved in any impact activities (i.e. soccer, football, skateboarding, wrestling, gymnastics, cheerleading, martial arts, hockey, etc.)? **Y** **N** If so, please list: _____

Parental Information

Mothers Occupation: _____

Fathers Occupation: _____

Does either parent smoke? **Y** **N** If yes, how much? _____

On a scale of 1-10 please rate the mothers stress level (1 = low and 10 = high):

Occupational _____

Personal _____

On a scale of 1-10 please rate the fathers stress level (1 = low and 10 = high):

Occupational _____

Personal _____

Stress History

Please indicate whether your child has **ever** experienced stress in any of the following areas. Your answers will enable us to determine which factors have contributed to your child's present health condition/concerns.

Estimate the stress level of your child: _____ (1 = low and 10 = high)

Childhood

Repeated/Prolonged Antibiotic Use	Y	N	Inhaler Use	Y	N
Car Accident	Y	N	Prescription Medications	Y	N
Childhood Illness	Y	N	Surgery	Y	N
Fall/Jump from a Height < 3 feet	Y	N	Vaccinations	Y	N
Fall/Jump from a Height > 3 feet	Y	N	Youth Sports	Y	N
Head Trauma	Y	N	Other Traumas (physical or emotional):		
Family Divorce	Y	N	_____		

Please check any of the following you have had in the last six months:

MUSCULO-SKELETAL

___ Low Back Pain
 ___ Pain Between Shoulders
 ___ Neck Pain
 ___ Arm Pain
 ___ Joint Pain/Stiffness
 ___ Walking Problems
 ___ Difficult Chewing/Clicking Jaw
 ___ General Stiffness
 ___ Scoliosis

NERVOUS SYSTEM

___ ADD/ADHD
 ___ Nervous
 ___ Numbness
 ___ Paralysis
 ___ Dizziness
 ___ Forgetfulness
 ___ Seizures
 ___ Confusion/Depression
 ___ Temper Tantrums
 ___ Fainting

GENITO-URINARY

___ Bladder Trouble
 ___ Painful/Excessive Urination
 ___ Discolored Urine
 ___ Bed Wetting

CARDIO-VASCULAR- RESPIRATORY

___ Chest Pain
 ___ Short Breath
 ___ Blood Pressure Problems
 ___ Irregular Heartbeat
 ___ Heart Problems
 ___ Lung Problems/Congestion
 ___ Varicose Veins
 ___ Ankle Swelling
 ___ Stroke
 ___ Asthma
 ___ Recurring Fevers

- Convulsions
- Cold/Tingling Extremities
- Stress
- Hearing Difficulty

GENERAL

- Fatigue
- Allergies
- Headaches
- Fever
- Growing Pains

GASTRO-INTESTINAL

- Poor/Excessive Appetite
- Excessive Thirst
- Frequent Nausea
- Vomiting
- Diarrhea
- Constipation
- Hemorrhoids
- Liver Problems

EYES, EARS, NOSE, THROAT

- Vision Problems
- Dental Problems
- Sore Throat
- Ear Aches/Infections
- Stuffed Nose
- Chronic Colds

MALE / FEMALE

- Menstrual Irregularity
 - Menstrual Cramps
 - Vaginal Pain/Infection
 - Breast Pain/Lumps
 - Prostate/Sexual Dysfunction
 - Other Problems:
-

- Colic
- Colitis
- Black/Bloody Stools
- Heartburn
- Gas/Bloating after Meals
- Abdominal Cramps
- Weight Trouble
- Gall Bladder Problems

Which best describes your reason for consulting our office? (check all that apply)

- I have a specific concern about my child's health and require help with this concern.
- I want to ensure that the health concerns of my child do not become an ongoing problem that will impact their future health.
- I want my child to be healthier five years from now than they are today.



TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective.

Chiropractic has only one goal. It is important that each patient understands both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment:

The adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine and/or extremities

Health:

The state of optimal physical, mental and social well-being, and not merely the absence of disease or infirmity.

Vertebral subluxation:

A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer diagnoses of or treat any disease. We only offer to diagnose either vertebral subluxations or neuro-musculoskeletal conditions. However, if during the course of a chiropractic spinal examination we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of another health care provider.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations or subluxation of the extremities. However, we may use other procedures to help your body hold the adjustments.

I, _____ have read and fully understand the above statements.
(print name)

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction.

Therefore, I accept chiropractic care on this basis.

(signature)

(date)

Consent to evaluate and adjust a minor child (check, fill, and sign below)

I, _____ being the parent or legal guardian of _____ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

(signature)

(date)

Pregnancy Release

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child. Date of last menstrual cycle. _____

(signature)

(date)

Naturally Right.....Chiropractic Care

Patient Health Information Consent Form

We want you to know how your Patient Health Information (**PHI**) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. I understand and agree to allow this chiropractic office to use their Patient Health Information (**PHI**) for the purpose of treatment, payment, healthcare operations (**TPO**), and coordination of care. I understand that I can refer to The Creating Wellness Center's Notice of Privacy Practices for a more complete description of such uses and disclosures.
2. I understand I have the right to examine and obtain a copy of my own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. With this consent, The Creating Wellness Center may call my home or other designated location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care. With my consent, The Creating Wellness Center may mail or email to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked personal and confidential. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. I have the right to provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures. By signing this form, I am consenting to The Creating Wellness Center's use and disclosure of my PHI to carry out TPO.

Name of Patient

Date

Signature of Patient or Legal Guardian

Fee Schedule

Examination

\$60	Insight Scans	<i>Consultation, Exam, and Report of Findings Workshop</i>
\$190	4 Scan Package	<i>(Save \$50)</i>
\$75	X-rays	
\$60	Wellness Assessment	<i>Consultation, Exam, and Report of Findings</i>
\$50	Additional Report of Findings	

Adjustments (Non-Third Party Reimbursement)

\$45	Individual	
\$70	Couple	<i>(Save \$20)</i>
\$90	You Plus Two	<i>(Save \$45 for family of 3)</i>

Couple and Family Per-Visit Discounts apply when immediate family members receive care together and where all dependent family members reside within the same household.

Individual Adjustment Packages (Non-Third Party Reimbursement)

<u>Family</u>	<u>150</u> Adjustments	\$4020	<i>(Save \$2730)</i>
	<i>*Ideal for Families up to 4 people. Monthly payments available for \$335.00 per month.</i>		
<u>Platinum</u>	<u>50</u> Adjustments	\$1850	<i>(Save \$400)</i>
	<i>*Ideal for Weekly Check-ups– Best Value. Monthly payments available for \$154.17 per month.</i>		
<u>Gold</u>	<u>25</u> Adjustments	\$1000	<i>(Save \$125)</i>
	<i>*Ideal for Bi-monthly Check-ups. Monthly payments available for \$166.67 per month.</i>		
<u>Silver</u>	<u>12</u> Adjustments	\$500	<i>(Save \$40)</i>
	<i>*Ideal for Monthly Check-ups.</i>		

Monthly Payments Available: *You may be eligible to finance your care at 0% interest for the term of your care plan. Ask our front desk for more specific information about making monthly payments toward our care packages.*

Discontinue Policy on Packages: *All services will be tallied according to our standard \$45 adjustment. If you have received less care than the amount paid, you will receive a refund.*

How can I utilize my Insurance at this office?

If you have insurance that covers active treatment chiropractic care, we will submit all of the information to get reimbursed from your insurance company and we will accept assignment in most cases. This includes your diagnosis and treatment records. If you choose to submit your own claims, we will provide receipts for your initial exam and then once per month afterward. You need only send in your receipts with your insurance company's claim form and your insurance company will communicate directly with you regarding your reimbursement. Remember, your agreement with your insurance company is a contract between you and them.

How are Medicare and Supplemental Insurance handled in this office?

This office files Medicare and Supplemental insurance claims. Medicare typically covers 80% of 12-30 Active Care Spinal Adjustments per calendar year. Your Supplemental Insurance Policy may pay the remaining 20% if it covers Chiropractic care. Medicare and Supplemental Policies will NOT cover Examinations, X-rays performed in this office or Maintenance Chiropractic care. If there is no Supplemental insurance, the 20% not paid by Medicare will be your responsibility. After your covered Active Treatment is completed, you will be eligible for our non-covered Maintenance/Wellness care plans.

What if I have been injured in an auto accident or on the job?

If you acquire insurance for a special situation such as an auto accident or a worker's compensation injury and choose to utilize that coverage, you will be charged our regular by-the-visit office fees until such claim is settled. Once a settlement has been made, you will then be eligible for our regular care plans.