



# Pediatric Intake Form

Birth to 2 months

Child's Legal Name: \_\_\_\_\_ Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ ST: \_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Parent's Cell Phone: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ Gender: M F Social Security #: \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Father's Name: \_\_\_\_\_

Sibling's Name(s) and ages: \_\_\_\_\_

How did you hear about our office? \_\_\_\_\_

Please select any of the applicable reasons that you are pursuing chiropractic care for your child:

- He/she is continuing care from another chiropractor.
- I recently had my spine checked and see the value in examining my child for subluxations.
- I'm concerned about his/her health and am looking for answers.
- He/She has a specific condition that concerns me. Please explain: \_\_\_\_\_
- I have been told that chiropractic care will benefit my child, however, I am not sure how it will help.

Is this visit the result of an auto injury? \_\_\_\_\_ If yes, when was it? \_\_\_\_/\_\_\_\_/\_\_\_\_

Do you have family members with similar health concerns? \_\_\_\_\_ If yes, who? \_\_\_\_\_

Has your child seen another doctor for the issue he/she is being seen today? \_\_\_\_\_

If yes, please provide name of doctor: \_\_\_\_\_

## INSURANCE INFORMATION

Insurance company: \_\_\_\_\_

Policy #: \_\_\_\_\_ Policy Holder: \_\_\_\_\_

**AUTHORIZATION AND RELEASE:** I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I understand and agree to allow this chiropractic office to use their Protected Health Information (PHI) for the purpose of treatment, payment, healthcare operations and coordination of care. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable. I understand that interest is charged on overdue accounts at the annual rate of 16%. The patient understands and agrees to allow this chiropractic office to use their Protected Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Protected Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Protected Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. The following person(s) have my permission to receive my personal health information: \_\_\_\_\_

Guardian's Signature Authorizing Care \_\_\_\_\_ Date \_\_\_\_\_



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## PRENATAL HISTORY

Was the patient adopted? \_\_\_\_\_ Were there complications during the pregnancy? \_\_\_\_\_ If yes, explain:

\_\_\_\_\_

Were ultrasounds performed during pregnancy? \_\_\_\_\_ If yes, how many? \_\_\_\_\_

Were medications/drugs/caffeine taken during pregnancy? \_\_\_\_\_ If yes, please list type and amount:

\_\_\_\_\_

Were cigarettes or alcohol used during pregnancy? \_\_\_\_\_ If yes, please list type and amount:

\_\_\_\_\_

Location of birth: \_\_\_\_\_ in hospital \_\_\_\_\_ in birthing center \_\_\_\_\_ at home

Birth Intervention:

\_\_\_\_\_ mother induced \_\_\_\_\_ mother medicated (Pitocin, etc.) \_\_\_\_\_ forceps \_\_\_\_\_ vacuum extracted

Were there complications during delivery? \_\_\_\_\_ If yes, please explain:

\_\_\_\_\_

Are there genetic disorders/disabilities? \_\_\_\_\_ If yes, please explain:

\_\_\_\_\_

## HEALTH HISTORY

Does baby have any known allergies? \_\_\_\_\_ If yes, to what? \_\_\_\_\_

Has your baby ever taken antibiotics? \_\_\_\_\_ If yes, what kind and when? \_\_\_\_\_

List any current medications: \_\_\_\_\_

List any past medications: \_\_\_\_\_

Has baby ever had any surgeries? \_\_\_\_\_ If yes, what surgery and when? \_\_\_\_\_

Has baby been diagnosed with cancer or any other illness? \_\_\_\_\_ If yes, please explain: \_\_\_\_\_

\_\_\_\_\_

## NEWBORN HISTORY

*The following questions are designed to help the doctor provide the best possible care for your child.*

How many hours does your baby sleep between feedings? During day: \_\_\_\_\_ at night: \_\_\_\_\_

Does baby sleep easily? Y N \_\_\_\_\_

Does baby have a preferred sleeping position? Y N \_\_\_\_\_

Does baby cry if you change this sleeping position? Y N \_\_\_\_\_

Does baby have any feeding difficulties? Y N \_\_\_\_\_

Is baby being breastfed? Y N If no, was baby ever breast fed? Y N How long? \_\_\_\_\_

Does baby have a one-sided breast feeding preference? Y N Which breast is preferred L R

Is baby formula fed? Y N Which formula or other milk source is used? \_\_\_\_\_

Does baby frequently spit-up after feeding? Y N \_\_\_\_\_

Does baby cry a lot? Y N For how many hours each day? \_\_\_\_\_

Does baby pass a lot of intestinal gas? Y N \_\_\_\_\_

Does baby have a preferred head position? Y N \_\_\_\_\_

Does baby frequently arch his/her head and neck backwards? Y N \_\_\_\_\_

Does baby cry or become irritable during a diaper change? Y N \_\_\_\_\_

Has baby ever had a fever? Y N \_\_\_\_\_

Approximately 50% of children fall head first from a high place during the first year of life (i.e. a bed, changing table, down stairs, etc.) Has baby had any falls? Y N \_\_\_\_\_

Has baby been in a car accident or near-miss? Y N \_\_\_\_\_

Has baby had any other trauma? Y N \_\_\_\_\_

Has baby been vaccinated? Y N \_\_\_\_\_

Do you have any other concerns you wish to discuss? \_\_\_\_\_

\_\_\_\_\_

## Insurance Questionnaire

The following questions are necessary so that we may properly file your insurance for you. These questions are taken directly from the insurance form that we must fill out and file for you. Please answer as fully as possible.



1. Type of insurance: Medicare\_\_\_\_ Medicaid\_\_\_\_ Group Health Plan\_\_\_\_ Other\_\_\_\_
2. Insured's ID Number\_\_\_\_\_
3. Patient Name:\_\_\_\_\_
4. Insured Name:\_\_\_\_\_
5. Insured date of birth: \_\_\_\_\_ SSN: \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_
6. Insured employer name or School name:\_\_\_\_\_
- City\_\_\_\_\_ State\_\_\_\_\_ Zip\_\_\_\_\_ Tel #\_\_\_\_\_
7. Insured's Address (if same as patient put "same"):\_\_\_\_\_
- City\_\_\_\_\_ State\_\_\_\_\_ Zip\_\_\_\_\_ Tel #\_\_\_\_\_
8. Patient Status: Single Married Other Employed Full-time Student Part-time Student
9. Is the condition we are treating related to current or previous employment? Yes\_\_\_\_ No\_\_\_\_
10. Is the condition we are treating related to an auto accident? Yes\_\_\_\_ No\_\_\_\_
11. Is the condition we are treating related to another type of accident? Yes \_\_\_\_ No\_\_\_\_
12. Is there another health benefit plan? Yes\_\_\_\_ No\_\_\_\_ If yes, list: \_\_\_\_\_

**Patient's or Authorized Person's Signature:** I authorize the release of any medical or other information necessary to process my insurance claim. This is to serve as a long-term authorization card.

Signed:

\_\_\_\_\_ Date:\_\_\_\_\_

**Insured's or Authorized Person's Signature:** I authorize payment of medical benefits to for the services described on the insurance form. This authorization is to apply to all occasions of service until it is revoked in writing. I agree to pay for services not covered by insurance and understand that I am ultimately responsible for payment in full at this office.

Signed:

\_\_\_\_\_ Date:\_\_\_\_\_

### MEDICARE ONLY

All doctors have been instructed to ask the following questions of all Medicare patients.

1. Do you or your spouse work for a company that provides you with health insurance? Yes\_\_\_\_ No\_\_\_\_
2. Are you entitled to Medicare because of End Stage Renal Disease? Yes\_\_\_\_ No\_\_\_\_
3. Is the illness or injury the result of an accident or illness that occurred at work? Yes\_\_\_\_ No\_\_\_\_
4. Is this illness or injury the result of an accident or other injury? Yes\_\_\_\_ No\_\_\_\_
5. Has the treatment for this accident or illness been authorized by the Veteran's Administration? Yes\_\_ No\_\_
6. Are you entitled to any benefits under the Federal Black Lung Program? Yes\_\_\_\_ No\_\_\_\_
7. Do you have a Medicare Medigap Policy? Yes\_\_\_\_ No\_\_\_\_ Name of Company\_\_\_\_\_
8. Do you have a Medicare Supplement Policy? (Policy provided by employer you retired from)? Yes\_\_\_\_ No\_\_\_\_