Pediatric Practice Member Intake Forms

Confidential Patient Information

Child's Name:	Parent/Guardian Name(s):		
Street Address:	City, State, Postal Code:		
Cell Phone:	Other Phone:	Child's Sex:	
Email:	Child's SSN:	Birthdate:	Age:
How did you hear about us?			
Who is your primary care physician?			
Is your child receiving care from other health professionals? ◯ Yes ◯ No If yes, please name them and their specialty:			
Please list any drugs/medications/vitamins/herbs or other that your child is taking:			

Current Health Conditions

What health condition(s) bring your child in to be evaluated by a chiropractor?
When did the condition first begin?
How did the problem start? ◯ Suddenly ◯ Gradually ◯ Post-Injury
Has your child ever received care for this condition? ◯ Yes ◯ No -If yes, please explain:
Is this condition: ◯ Getting worse ◯ Improving ◯ Intermittent ◯ Constant ◯ Unsure
What makes the problem better?
What makes the problem worse?

Quadruple Visual Analogue Scale

Please circle the number that best describes the question asked. If you have more than one complaint, please answer each question for each individual complaint and indicate the score of each complaint.

EXAMPLE: No Pain ——— Worst Possible Pain

Back pain Headaches

0 1 2 3 4 (5) 6 7 (8) 9 10

1 How would you rate your pain RIGHT NOW?

0 1 2 3 4 5 6 7 8 9 10

2 What is your typical or AVERAGE pain?

0 1 2 3 4 5 6 7 8 9 10

3. What is your pain level at its BEST? (How close to 0 does your pain get at its best?)

0 1 2 3 4 5 6 7 8 9 10

What percentage of your awake hours is your pain at its best?_____%

4. What is your pain level at its WORST? (How close to 10 does your pain get at its worst?)

0 1 2 3 4 5 6 7 8 9 10

What percentage of your awake hours is your pain at its worst?_____%

Health Goals for your child

What are your top three health goals for your child?

1._____

2._____

3._____

What would you like to gain?

- ◯ Resolve existing condition
- ◯ Overall Wellness
- ◯ Both

Has your child ever visited a chiropractor? ◯ Yes ◯ No - If yes, what is their name:

-What is their specialty: ◯ Pain Relief ◯ Physical Therapy & Rehab ◯ Nutrition ◯ Subluxation-based ◯ Other:

Pregnancy & Fertility History

Please tell us about your pregnancy:

Any fertility issues? ◯ Yes ◯ No If yes, please explain _____

Did mother drink? ◯ Yes ◯ No If yes, please explain _____

Did mother exercise? ◯ Yes ◯ No If yes, please explain _____

Was mother ill? ◯ Yes ◯ No If yes, please explain _____

Any ultrasounds? ◯ Yes ◯ No If yes, please explain _____

Please explain any noticeable episodes of mental or physical stress during pregnancy:

Please explain any other concerns or notable remarks about your child's conception or pregnancy:

Labor & Delivery History

Child's birth was: ◯ Natural vaginal birth ◯ Scheduled C-section ◯ Emergency C-section
-At how many weeks was your child born?

Where was your child born? - Who delivered your baby?

Please indicate any applicable interventions or complications:
◯ Breech ◯ Induction ◯ Pain Meds ◯ Epidural ◯ Episiotomy ◯ Vacuum Extraction ◯ Forceps
◯ Other:

Please describe any other concerns or notable remarks about your child's labor and/or delivery:

Child's birth weight: Childs birth height:

APGAR score at birth: APGAR score after 5 min:

Growth & Development History

Is/was your child breastfed? ◯ Yes ◯ No -If yes, how long? Difficulty with breastfeeding? ◯ Yes ◯ No

Did they ever use formula? ◯ Yes ◯ No -If yes, at what age? -If yes, what type?

Did/does your child suffer from colic, reflux, or constipation as an infant? ◯ Yes ◯ No
-If yes, please explain:

Did/does your child frequently arch their neck/back, feel stiff, or bang their head? ◯ Yes ◯ No
-If yes, please explain:

At what age the child: Respond to sound:_____ Follow an object:_____ Hold their head up:_____ Vocalize:_____
Teethe:_____ Sit alone:_____ Crawl:_____ Walk:_____ Begin cow's milk:_____ Begin solid foods:_____

Please list any food intolerances or allergies, and when they began:

Please list your child's hospitalizations and surgical history (including this year):

Please list any major injuries, accidents, falls and/or fractures your child has sustained in his/her lifetime (including this year):

Have you chosen to vaccinate your child? ◯ No ◯ Yes, on a delayed or selective schedule ◯ Yes, on schedule
In yes, please list any vaccine reactions:

Has your child received any antibiotics? ◯ Yes ◯ No
-If yes, how many times and list reason:

Night terrors or diffculty sleeping? ◯ Yes ◯ No -If yes, please explain:

Behavorial, social or emtional stress? ◯ Yes ◯ No -If yes, please explain:

How many hours per day does your child typically spend watching TV, computer, tablet or phone?

Growth & Development History cont'd

How would you describe your child's diet? ◯ Mostly, whole, organic foods ◯ Pretty average ◯ High amount of processed foods

Does your child participate in organized sports? ◯ Yes ◯ No

If yes, have they ever sustained any injury: ◯ Yes ◯ No

If yes, please explain:

INFORMED CONSENT FOR CHIROPRACTIC CARE

Chiropractic care, like all forms of health care, while offering considerable benefits may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases, injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include: sprain/strain injuries, irritation of a disc condition, and rarely, fractures. One of the rarest complications associated with chiropractic care occurring at a rate between one instance per one million to one per two million cervical spine (neck) adjustments may be a vertebral injury that could lead to a stroke.

Prior to receiving chiropractic care in this chiropractic office, a health history and physical examination will be completed. These procedures are performed to assess your specific conditions, your overall health and in particular, your spinal health. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies are needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan prior to beginning care.

- I understand and accept that there are risks associated with chiropractic care and give consent to the examination that the doctor deems necessary and the chiropractic care, including spinal adjustments, as reported following my assessment.
- I authorize and request payment of insurance benefits directly to Patrick McDonnell, D.C. I agree that this authorization will cover all services rendered until I revoke the authorization. I agree that a photocopy of this form may be used in place of the original. All professional services rendered are charged to the practice member. It is customary to pay for services when rendered unless other arrangements have been made in advance. I understand that I am financially responsible for charges not covered by this assignment.

Print name: _____

Signature:_____ Date:_____

If This Health Profile is for a Minor/Child, Please Fill Out and Sign Below Written Consent for a Child

Name of Practice Member who is a minor/child:_____

I authorize Dr. Patrick McDonnell D.C. and all Proper Chiropractic staff to perform diagnostic procedures, radiographic evaluations, render chiropractic care, and perform chiropractic adjustments to my minor/child. As of thisdate, I have the legal right to select and authorize health care services for my minor/child. If my authority to select andauthorize care is revoked or altered, I will immediately notify Proper Chiropractic.

Guardian signature:_____ Date:_____

Relationship to minor/child: _____

Notice of Privacy Practices Acknowledgement

I understand that I have certain rights of privacy regarding my protected health information, under the Health InsurancePortability & Accountability Act of 1996 (HIPPA). I understand that this information can and will be used to:

1. Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may beinvolved in that treatment directly and indirectly.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations, such as quality assessments and physicians' certifications.

I acknowledge that I may request your NOTICE OF PRIVACY PRACTICES containing a more complete descriptionof the uses and disclosures of my health information. I also understand that I may request, in writing, that you restricthow my private information is used to disclose to carry out treatment, payment, or healthcare operation. I also understand you are not required to agree to my requested restrictions, but if you agree, then you are bound to abide bysuch restrictions.

Signature: _____ Date:_____