Sunset Hills Chiropractic
Creating Healthy Families

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Freedom Chiropractic

Pediatric Chiropractic Intake Form (Children under 13)

Patient Name _____ Today's Date:___/___/___

Birth Date: ____/____/____ Age:_____ Gender: ☐ Male ☐ Female

Street: _____

City:_____ State: _____ Zip Code: _____

Mother's Phone: (_____)_____ Father's Phone: (_____)_____

Would you like to receive Text Message Reminders for future appointments? ☐ Yes ☐ No
Which Parent would like to receive the reminder? _____

Child's Height: _____Child's Weight: _____

Pediatrician/Family MD: _____ Phone: (_____)_____

Has your child been adjusted by a chiropractor before? ☐ Yes ☐ No

Previous Chiropractor's Name: _____

PREGNANCY HISTORY:

Third Trimester Presentation: □ Vertex □ Breech □ Transverse □ Face/Brow

Type of Birth: □ Vaginal □ Forceps □ Cesarean □ Suction Cap or Vacuum

Location: □ Home □ Hospital □ Birthing Center □ Other:_____

Were there complications during Pregnancy? ☐ Yes ☐ No Explain: _____

Were there complications during delivery? ☐ Yes ☐ No Explain: _____

Was there presence of: ☐ Jaundice? (Yellow) ☐ Cyanosis? (Blue) ☐ Congenital Anomalies/Defects?
If yes, please explain: _____

INFANT HISTORY:

Feeding: □ Breast: _____ # of Months: □ Bottle: _____ # of Months: □ Formula: _____ # of Months: _____
Brand(s): _____

Number Of Hours of Sleep Per Night: _____ Quality of Sleep: □ Good □ Fair □ Poor

Has your child received vaccinations? ☐ Yes □ No
☐ Suggested Schedule ☐ Alternative Schedule

DEVELOPMENTAL/HEALTH HISTORY:

Childhood Diseases: (Check all that apply)

□ Chicken Pox □ Mumps □ Measles □ Rubella □ Whooping Cough □ Other: _____

According to the National Safety Council, approximately 50% of children fall head first from a high place during their first year of life (i.e) a bed, changing table, down stairs, etc.).

Was this the case with your child? □ Yes □ No Explain: _____

Please Check any of the following conditions that your child has now or has had in the past. While they may seem unrelated to the purpose of the appointment, they can affect the overall diagnosis and care plan.

□ Colic	□ Seizures	□ Scoliosis	□ Recurring Fevers
□ Ear Infections	□ Bedwetting	□ Headaches	□ Digestive Problems
□ Colds	□ Hyperactivity	□ Back Pain	□ Acid Reflux
□ Asthma	□ Temper Tantrums	□ Growing Pains	□ Poor Nutrition
□ Allergies	□ Sleeping Problems	□ Hearing Problems	□ Limited Exercise
□ Sinus Problems	□ Anxiety/ADHD	□ Dizziness	□ Low Energy

□ Other Health Problems: _____

REASON FOR THIS VISIT

Describe the purpose of this visit: _____

When and how did this health challenge begin? _____

Since the problem began is it:

□ Getting Better □ Getting Worse □ About the same

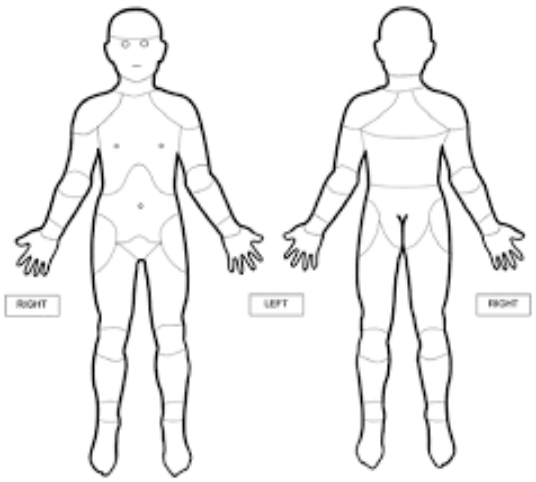
What is the pattern of this problem?

□ Constant □ Intermittent □ Occasional □ Cyclic

Have you seen other professionals for this condition? □Yes □ No

Name of professional: _____

Use the diagram to the right to indicate with an X where you or your child notices discomfort or problems occurring



AUTHORIZATION FOR CARE OF A MINOR

I hereby grant permission to Sunset Hills Chiropractic • Freedom Chiropractic to perform chiropractic examinations and therapeutic procedures including but not limited to spinal adjustments, ultrasound, heat/ ice application, electrotherapy, and manual muscle therapy that are considered safe and effective methods of care.

I understand that any procedure intended to help may have complications. While the chances of experiencing complications are small it is the practice of this clinic to inform our patients about them. These complications include, but are not limited to, soreness, inflammation, soft tissue injury, dizziness, burns, and temporary worsening of symptoms. More serious complications are extremely rare. Additional information on side-effects and complications is available upon request.

I have read and understand the above statements regarding treatment side effects. I also understand that there is no guarantee or warranty for a specific cure or result.

_____ ____/____/____

Minor's Name Date of Birth

_____

Printed name of Parent/Guardian

_____ ____/____/____

Signature of Parent/Guardian Today's Date

Patient Acknowledgement and Receipt of Notice of Privacy Practices Pursuant to HIPAA and Consent for Use of Health Information

Patient Name: _____ Date : _____/_____/_____

The Undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant to HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request.

In Order for our office to provide ANY information to your Spouse, parent, relative or other designates, we must have your permission. (This would include appointment schedules, X-Rays, receipts, Insurance Information, health records and any other information that pertains to your treatment.) You may indicate your permission by listing names here:

My information may be shared with: (List Names and relationship to patient)

Please indicate the name and contact information of your primary care physician for the purpose of care coordination with the chiropractic physician.

Primary Care Doctor Name: _____

Address/Phone: _____

The undersigned does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA Compliance Manual, State Law and Federal Law.

_____

Patient Signature

If patient is a minor or under a guardianship order as defined by State law:

_____

Signature of Parent/Guardian (circle one)

Informed Consent to Chiropractic Treatment

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including various modes of physical therapy, and if necessary, electrical muscle stimulation, or spinal traction on me (or on the patient named below, for whom I am legally responsible:_____) by the chiropractic physician and/or anyone working in this office authorized by the chiropractic physician.

I further understand that such chiropractic services may be performed by the Physician of Chiropractic named here: **Dr. Brittany Warren / Dr. Robyn Kuhn / Dr. Nathan Free**, and/or other Physicians of Chiropractic who may treat me now or in the future at this office. I have had an opportunity to discuss with the Doctors of Sunset Hills and Freedom Chiropractic and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine and all health care, the practice of chiropractic carries some risks to treatment, including but not limited to: fractures, disc injuries, strokes (CVA), dislocations, and sprains. I do not expect the physician to be able to anticipate and explain all risks and complications. Further, I wish to rely on the physician to exercise judgment during the course of the procedures which the physician feels are in the best interests at the time, based upon the facts then known.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its contents, and by signing below, I agree to the treatment recommended by my physician. I intend this consent form to cover the entire course of treatment for my present condition(s) and for any condition(s) for which I seek treatment at this facility.

To be completed by the patient:

_____

Print Patient's Name

_____

Signature of Patient

To be completed by the patient's representative, if necessary, (eg: if the patient is a minor or is physically or mentally incapacitated)

_____

Print Name of Patient

_____

Print Name of Representative

_____

Signature of Representative