CHIROPRACTIC PEDIATRIC INTAKE FORM

PERSONAL INFORMATION

Child's Full Name:_____ Today's date: _____

Preferred Name: _____ Age: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Parents' Names: _____Contact Phone: _____

Parent Email for Appointment Reminders ONLY:_____

Pediatrician: _____ Phone: _____

How did you hear about our office? _____

PURPOSE OF CARE

Please answer all questions on behalf of your child:

What is/are the health condition(s) you are concerned with today?

*Major concern? _____

*Onset (when *and* how did it begin)? _____

Is this condition *(please circle)*: getting worse constant comes and goes

Is this condition interfering with your *(please circle)*: school sleep daily routine

Have you had this or similar conditions in the past? _____

Have you been treated by a medical doctor for this condition? _____

If so, where? _____ Results? _____

Have you ever had Chiropractic Care before? _____

If so, whom? _____ Results? _____

HEALTH HISTORY

Please explain any difficulties during pregnancy or labor/birth: _____

_____

Prenatal/Birth Information (circle appropriately):

Place: Home / Birth Center / Hospital

Type: Vaginal / C-Section

Procedures / Complications:

Face Presentation	Breech Presentation	Antibiotics / GBS +
Forceps / Vacuum	Anesthesia / Epidural	Terbutaline OR Mag Sulfate
Induction / Pitocin	Neonatal Intensive (NICU)	Other:_____

Nutrition:

- Breastfed , if not currently, how long? _____
- Formula (soy / whey)
- Combination

First solid food was given at what age? _____

Vaccines:

- Not vaccinated
- Partially vaccinated – started, but changed your mind OR alternate schedule
- Fully vaccinated

Sleep:

How many naps?_____ How long are the naps?_____

How many continuous hours of sleep at night?_____

PERSONAL HEALTH HISTORY

*Has this child ever suffered from (check appropriately)***:**

- Acne
- ADD/ADHD / Behavioral Problems
- Antibiotics, if so, how many rounds? ___
- Asthma
- Allergies
- Anemia/Blood Disorders
- Anxiety Disorders
- Back or Neck Pain
- Bedwetting
- Car Accident
- Childhood Diseases (chicken pox, etc.)
- Chronic colds /Infections
- Colic
- Diabetes
- Digestive Problems
- Ear Infections
- Eczema/Psoriasis
- Fall from a changing table, bed, etc.

- Fevers
- Growing pains / extremity pain
- Headaches
- Hospitalization
- Seizures
- Poor Appetite
- Recurrent antibiotic use
- Vaccine Reactions

My child has met all developmental milestones: Yes / No

Please list any other serious medical condition(s):_____

Allergies to foods or medications: _____

Surgeries: _____

Past Serious Accidents: _____

Please answer the following as completely as possible. Does your child:

Take supplements or vitamins? _____

Take Prescription Drugs? Please list: _____

Follow a special diet? _____

Carry a backpack (what style)? _____

Play Sports (which one(s))? _____

Watch TV (amount/day)?_____ Play Computer/Video Games (amount/day)?_____

FAMILY HEALTH HISTORY

Please indicate the conditions below, if the child's immediate family member has had the following:

YES?	FAMILY HEALTH CONDITION	WHOM? (Specify Paternal/Maternal)
	Arthritis	
	Cancer	
	Diabetes	
	Digestive Disorders	
	Heart Disease (cholesterol/heart attack)	
	High Blood Pressure	
	Musculoskeletal Disease	
	Osteoporosis	
	Psychological Disorders / Mental Illness	
	Reproductive / Fertility Difficulties	
	Stroke	

	Thyroid Disease	
	Tuberculosis	
	Vaccine Reactions	

WELLNESS PROFILE

Chiropractic care affects more than just our muscles and bones. Please share with us what health goals you hope to find for your child. Indicate as many goals as you wish.

- more energy
- better sleep
- freedom from pain
- easier breathing
- balanced posture
- improve nutrition
- improved coordination
- reduce medications
- improve overall health
- better sports performance
- enhanced emotional well-being
- better concentration
- greater resistance to disease
- relief care for current symptoms
- other _____

OFFICE POLICIES

Office Payment Policies

I clearly understand and agree that I am personally responsible for payment at the time of my child's visit, including any and all services rendered to my child. I understand and agree that health and accident insurance policies are an arrangement between the insurance carrier and myself, therefore, I am responsible for payment. I realize that Dr. James is NOT contracted with ANY insurance company, therefore, I understand it is unlikely that I will be reimbursed for my child's care in this office.

Patient/Legal Guardian's Initials: _____

Consent to Treat a Minor

I hereby authorize Thomas James, DC and Dr. Nancy James, DC to administer chiropractic care and nutritional recommendations to my son/daughter as they may deem necessary. I affirm that the above is true and correct. I consent to chiropractic care for my child in this office.

_____ _____

Parent/Legal Guardian Date

HIPPA Procedures and Authorization

Protecting the privacy of your personal health information is important to us. This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully. Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment, or practice operations will be made only after obtaining your consent. You may request restrictions on disclosures.

Disclosures of protected health information are limited to the minimum necessary for the purpose of the disclosure. This provision does not apply to the transfer of medical records for treatment.

You may inspect and receive copies of your records within 30 days of a request to do so. There may be a reasonable cost-based fee for photocopying, postage and preparation.

You may request changes to your records. Our practice has the right to accept or deny your request.

We maintain a history of protected health information disclosures that is accessible to you.

In the future, we may contact you for appointment reminders, announcements, and to inform you about our practice and its staff.

Our practice is required to abide by this notice. We have the right to change this notice in the future. Any revisions will be prominently displayed in a clearly visible location in our office.

You may file a complaint about privacy violations by contacting our office at 949-661-2688.

I certify that I'm the parent or legal guardian. I have read/understand the included information given to me and certify it to be true and accurate to the best of my knowledge. I consent to the collection and use of the above information to this office of chiropractic.

I authorize this office and its staff to examine and treat my condition as the doctors see fit. I hereby authorize the doctor to release all information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursement of charges incurred by me. I grant the use of my signed statement of authorization with my signature for required insurance submissions. I understand and agree that all services rendered to me will be charged to me, and I'm responsible for timely payment of such services. I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and me. I understand that fees for professional services will become immediately due upon suspension or termination of my care or treatment.

Patient Name: _____ DOB:_____

Parent/Guardian Name:_____

Parent/Guardian Signature:_____ Date: _____

CONSENT TO INITIATE CARE

Welcome to my office. In order to provide for the most effective healing environment, most effective application of chiropractic procedures and the strongest possible doctor-patient relationship, it is our wish to provide each patient with a set of parameters and declarations that will facilitate the goal of optimum health through chiropractic. To that end, we ask that you acknowledge the following points regarding chiropractic care and the services that are offered through this practice:

A. **Chiropractic** is a licensed health care discipline, which emphasizes the inherent recuperative power of the body to heal itself without the use of drugs or surgery.

B. **The Practice of Chiropractic** focuses on the relationship between structure (primarily the spine) and function (as coordinated by the nervous system) and how that relationship affects the preservation and restoration of health.

C. **Chiropractic evaluation and examination** is part of the standard chiropractic procedure. It is designed to identify health problems and chiropractic needs. Doctors of Chiropractic focus particular attention on prevention and correction of **Subluxation**.

D. **Subluxation** (particularly of the spine) is a complex of alignment, movement and/or pathological joint abnormalities that chokes off or compromises nerve integrity causing abnormal organ system function and ill health.

E. **Chiropractic Adjustment** is a very specific manipulation, only performed by licensed chiropractors, to eliminate **Subluxation** and allow normal nerve function and health restoration. Chiropractic Adjustments are safe, effective procedures applied over one-million times each day in the United States alone.

F. **Prevention of Subluxation** is accomplished through **maintenance adjustments** and nutritional, mental, and physical wellness habits taught and prescribed by Doctors of Chiropractic. Based on your condition, this office may also utilize adjunct therapeutic procedures as well.

G. **We invite you to speak frankly to the doctor or staff** on any matter related to your care at our office. We work to maintain as a supporting, open environment.

H. We do not seek to replace or compete with medical, dental or other type(s) of health professionals and will provide referral for other evaluation if the doctor feels it is the best interest of his patient. Those providers retain responsibility for the care and management of medical conditions. We do not offer advice regarding treatment prescribed by other providers.

I. **Your compliance** with Chiropractic Adjustment schedules and instructions is essential to maximum healing and optimal health through Chiropractic. We will work diligently to help you meet your Chiropractic needs.

J. **Cancellation Policy:** Your time is invaluable, as is Dr. James. Your appointment time is reserved for you and we do our best to give you the care you deserve and need with minimal to no wait. Please give adequate notice for cancelled or rescheduled appointments or a fee may apply.

We are committed to providing the highest quality care possible so that you and your family may enjoy an active, healthy life, with affordable fees. Thank you for taking the first step towards restoring and maintaining your spinal health.

I understand all of the above information and give consent for chiropractic and nutritional evaluations and care to be performed by Thomas James, DC and/or Nancy James, DC.

Patient or Guardian's Signature_____ **Date** _____

Print Name_____