Pediatric Intake Form

Ages 0-12

Date:_____

Name_____ Nickname_____

Date of Birth_____ Age_____ Referred By_____

Name of Parents_____ Race (please circle one): White African American

American Indian Alaska Native Asian Hawaiian or Pacific Islander Other Preferred Language:_____

Ethnicity (please circle one): Hispanic or Latino Not Hispanic or Latino Emergency Contact_____

Address_____

City_____ State_____ Zip Code_____

Home Phone_____ Cell Phone_____

Email address_____

Please check the purpose for your child's visit: ☐ early detection ☐ crisis management ☐ prevention ☐ wellness

☐ maximizing normal growth and development

Please answer the following questions to the best of your ability. If the question does not apply, please write NA.

Has your child been checked by a Doctor of Chiropractic? ☐Yes ☐No

Name of Chiropractor/last seen?_____

Who is your regular Pediatrician?_____

PRESENT HEALTH CONCERNS:

Primary reason you are here_____

Does your child complain of any pain? If yes, where?_____

How do they describe the pain?_____ How often do they complain of pain?_____

Does anything make the pain worse?_____ Anything make the pain better?_____

Is this problem interfering with your child's sleep? ☐ Yes ☐No Eating? ☐yes ☐ No Daily Routine? ☐Y ☐N

Check any of the following conditions your child has had or is suffering from:

☐Colic	☐Ear Infections	☐ Sleep Problems	☐Night Terrors	☐Learning Difficulties
☐Allergies	☐Asthma	☐Headaches	☐Constipation	☐Emotional Disorder
☐Tantrums	☐ADD/ADHD	☐Muscle Cramps	☐Infections/Colds	☐Upper/Midback Pain
☐Dizziness	☐Fatigue	☐Depression	☐Sore Throats	☐Bloating/Gas
☐Neck Pain	☐Bed Wetting	☐Low Back Pain	☐Loss of Concentration	☐Diarrhea
☐Scoliosis	☐Sensory Processing		☐Lactation Difficulties	☐Eating difficulties
☐Failure to Thrive		☐Weight loss	☐Weight gain	☐Eczema
☐Rash	☐Food sensitivities	☐Plagiocephaly	☐Other_____	☐other_____

BIRTH HISTORY

What was the child's gestational age at birth? _____weeks ____ days
Birth Weight_____ lbs_____ oz Birth Length _____ inches
Place of birth: Home Birthing Center Hospital Duration of Birth_____
Type of birth: ☐Vaginal ☐C-Section Provider: ☐ Midwife ☐OB-GYN
Was your child born ☐Cephalic (head first) ☐Breech (feet first)
Were there any complications? ☐Yes ☐No If Yes, please explain_____
Birth Trauma: ☐Doctor assisted ☐Twisting/Pulling ☐Vacuum Extraction ☐Forceps
Was Labor induced? ☐Yes ☐No If yes, why_____
Were medications or epidurals given to the mother during birth? ☐ Yes ☐No

GROWTH & DEVELOPMENT

Was the infant alert and responsive within 12 hours of delivery? ☐yes ☐No
If no, please explain _____
At what age did the child: Respond to sound_____ Follow an object_____
Hold up head_____ Vocalize _____
Sit alone _____ Teethe _____
Crawl _____ Walk _____
Did/does your child have a normal cross crawl pattern to their crawl? ☐ Y ☐ N
Have you ever noticed anything "unique" about your child's crawl? ☐ Y ☐N
Does your child sleep: ☐front ☐back ☐ side
Do you consider the child's sleeping pattern normal? ☐ Yes ☐NO How many hours per day? _____
If no, please explain _____

PHYSICAL STRESSORS

Since problems that chiropractors look for and detect can be related to many types of stressors, the following information is also very important to us.
Any traumas to the mother during pregnancy? (ie, falls, accidents, etc) ☐ Yes ☐ No
If yes, please explain _____
Any evidence of birth trauma to the infant?
☐ bruising ☐ stuck in birth canal ☐respiratory depression ☐ odd shaped head
☐ fast or excessively long birth ☐cord around neck
Any falls from couches, beds, changing tables, etc ☐ Yes ☐No
If yes, please explain _____
Any traumas resulting in bruises, cuts, stitches or fractures?☐ yes ☐ No
If yes, please explain _____
Any hospitalizations or surgeries? ☐ Yes ☐No
If yes, please explain _____
Any sports played? ☐Yes ☐No If yes, please list _____
Is a school back pack used ☐Yes ☐No Is it ☐ heavy or ☐ light

CHEMICAL STRESSORS

Was the child breast-fed? ☐ Yes ☐ No If yes, how long? _____
Formula introduced at what age? _____ Began solid foods at what age: _____
Types of solid foods:_____
Food/Juice intolerance? ☐ Yes ☐ No Type: _____

Is your child on or have taken any medications? _____
During the mother's Pregnancy:
Did the mother smoke? ☐ Yes ☐ No How Much?_____
Drink alcohol? ☐ Yes ☐ No How Much?_____
Any illnesses during the pregnancy? ☐ Yes ☐ No If Yes, please describe_____
Any drugs taken during pregnancy? ☐ Yes ☐ No _____
Any ultrasounds? ☐ Yes ☐ No How many?_____ Reasons for being done:_____
Any invasive procedures during pregnancy (ie amniocentesis, Chorionic villi sampling, etc)? ☐ Yes ☐ No
If Yes, please explain_____
Any pets at home? ☐ Yes ☐ No
Any smokers in the home? ☐ Yes ☐ No
Any antibiotics given? ☐ Yes ☐ No If Yes, reason_____
How often do they receive processed foods, white sugar, gluten (flour), dairy in their diet? ☐ Never
☐ on weekends ☐ A few times per week ☐ Daily ☐ nearly each meal ☐ on special occasions
Are you aware of any foods or additives that impact your child's behavior? ☐ Yes ☐ No If yes, what?_____

PSYCHOSOCIAL STRESSORS

Any difficulties with lactation? ☐ Yes ☐ No _____
Any problems with bonding? ☐ Yes ☐ No _____
Any behavioral problems? ☐ Yes ☐ No _____
Any inattention? ☐ Yes ☐ No _____
Any hyperactivity or restlessness? ☐ Yes ☐ No _____
Any difficulties at daycare or school? ☐ Yes ☐ No _____
Any challenges with learning deficiencies? ☐ Yes ☐ No _____
Any night terrors, sleep walking, difficulty sleeping? ☐ Yes ☐ No _____
Any prolonged temper tantrums or separation anxiety? ☐ Yes ☐ No _____
Is the child in day care? Baby sitter? ☐ Yes ☐ No _____
Is the child home schooled? ? ☐ Yes ☐ No
Average number of hours of television per week? _____
Average number of hours of video games per week? _____
Does your child have a cell phone? ☐ Yes ☐ No How often do they text or use the phone?_____
Do you feel your child's social and emotional development is normal for their age? ? ☐ Yes ☐ No

_____

Thank you for completing this form. If you have anything to add below, please add notes, which can then be discussed with the doctor. If there are any other questions or concerns that you have, please discuss with the doctor.

AUTHORIZATION AND RELEASE: 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. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records
Parent or Guardian Authorizing Care Signature_____Date_____
Relationship to child_____

Oceanside Chiropractic

INFORMED CONSENT

We encourage and support a **shared decision making process** between us regarding your health needs. As a part of that process you have a right to be informed about the condition of your health and the recommended care and treatment to be provided to you so that you can make the decision whether or not to undergo such care with full knowledge of the known risks. This information is intended to make you better informed in order that you can knowledgably give or withhold your consent.

Chiropractic is based on the science which concerns itself with the relationship between structures (primarily the spine) and function (primarily of the nervous system) and how this relationship can affect the restoration and preservation of health.

Adjustments are made by chiropractors in order to correct or reduce spinal and extremity joint subluxations. **Vertebral subluxation** is a disturbance to the nervous system and is a condition where one or more vertebra in the spine is misaligned and/or does not move properly causing interference and/or irritation to the nervous system. The primary goal in chiropractic care is the removal and/or reduction of nerve interference caused by vertebral subluxation.

A chiropractic examination will be performed which may include spinal and physical examination, orthopedic and neurological testing, palpation, specialized instrumentation, radiological examination (x-rays), and laboratory testing.

The chiropractic adjustment is the application of a precise movement and/or force into the spine in order to reduce or correct vertebral subluxation(s). There are a number of different methods or techniques by which the chiropractic adjustment is delivered but are typically delivered by hand. Some may require the use of an instrument or other specialized equipment. In addition, physiotherapy or rehabilitative procedures may be included in the management protocol. Among other things, chiropractic care may reduce pain, increase mobility and improve quality of life.

In addition to the benefits of chiropractic care and treatment, one should also be aware of the existence of some risks and limitations of this care. The risks are seldom high enough to contraindicate care and all health care procedures have some risk associated with them.

Risks associated with some chiropractic treatment may include soreness, musculoskeletal sprain/strain, and fracture. Risks associated with physiotherapy may include the preceding as well as allergic reaction and muscle and/or joint pain. In addition there are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke; rather, recent studies indicate that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence, there is a stroke already in process. However, you are being informed of this reported association because a stroke may cause serious neurological impairment.

I have been informed of the nature and purpose of chiropractic care, the possible consequences of care, and the risks of care, including the risk that the care may not accomplish the desired objective. Reasonable alternative treatments have been explained, including the risks, consequences and probable effectiveness of each. I have been advised of the possible consequences if no care is received. I acknowledge that no guarantees have been made to me concerning the results of the care and treatment.

I HAVE READ THE ABOVE PARAGRAPH. I UNDERSTAND THE INFORMATION PROVIDED. ALL QUESTIONS I HAVE ABOUT THIS INFORMATION HAVE BEEN ANSWERED TO MY SATISFACTION. HAVING THIS KNOWLEDGE, I KNOWINGLY AUTHORIZE OCEANSIDE CHIROPRACTIC, LLC TO PROCEED WITH CHIROPRACTIC CARE AND TREATMENT.
DATED THIS ____ DAY OF _____, 20___

_____

Patient Signature

Parental Consent for Minor Patient:

Patient Name: _____
Patient age: _____ DOB: _____
Printed name of person legally authorized to sign for Patient: _____
Signature: _____
Relationship to Patient: _____

In addition, by signing below, I give permission for the above named minor patient to be managed by the doctor even when I am not present to observe such care.

Printed name of person legally authorized to sign for Patient: _____
Signature: _____
Relationship to Patient: _____

Oceanside Chiropractic

HEALTH CARE AUTHORIZATION FORM

I have been provided with a copy of the Notice of Privacy Practices for Protected Health Information. The Notice of Privacy Practices describes the types of uses and disclosures of my Protected Health Information (PHI) that will occur in my treatment, payment of my bills or in the performance of health care operations of this chiropractic office. A copy of our notice is attached and we encourage you to read it and request your own copy if you would like one.

This Notice of Privacy Practices also describes my rights and duties of the Chiropractor with respect to my protected health information. I hereby give permission to Oceanside Chiropractic, LLC to use and/or disclose Protected Health Information in accordance with the following:

SPECIFIC AUTHORIZATIONS:

- I give permission to Oceanside Chiropractic, LLC to use my address, phone number and clinical records to contact me with appointment reminders, missed appointment notification, birthday cards, holiday related cards, newsletters, information about treatment alternatives or other health related information.

- If Oceanside Chiropractic, LLC contacts me by phone, I give them permission to leave a phone message on my answering machine or voice mail.

- I give permission to Oceanside Chiropractic, LLC to use my name on a welcome board, referral board, and birthday board.

- I give permission to Oceanside Chiropractic, LLC to use my photograph on their patient picture bulletin board and other marketing materials such as their brochure, website and ads in print media.

- I give permission to Oceanside Chiropractic, LLC to use any testimonial written by me for marketing purposes such as, sharing with other patients or potential patients, in their brochure, on their website or in ads in print media.

- I give Oceanside Chiropractic, LLC permission to treat me in an open room where other patients are also being treated. I am aware that other persons in the office may overhear some of my protected health information during the course of care. Should I need to speak with doctor at any time in private, the doctor will provide a room for these conversations.

- By signing this form you are giving Oceanside Chiropractic, LLC permission to use and disclose your protected health information in accordance with the directives listed above.

The use of this format is intended to make your experience with our office more efficient and productive as well as to enhance your access to quality health care and health information. This authorization will remain in effect for the duration of my care at Oceanside Chiropractic, LLC plus 7 years or until revoked by me.

RIGHT TO REVOKE AUTHORIZATION:
You have the right to revoke this AUTHORIZATION, in writing, at any time. However, your written request to revoke this AUTHORIZATION is not effective to the extent that we have provided services or taken action in reliance on your authorization.

You may revoke this AUTHORIZATION by mailing or hand delivering a written notice to the Privacy Official of Oceanside Chiropractic, LLC. The written notice must contain the following information:

Your name, Social Security number and date of birth;
A clear statement of your intent to revoke this AUTHORIZATION;
The date of your request; and
Your signature.

The revocation is not effective until it is received by the Privacy Official.

This AUTHORIZATION is requested by Oceanside Chiropractic, LLC for its own use/disclosure of PHI. *(Minimum necessary standards apply.)*

I have the right to refuse to sign this AUTHORIZATION. If I refuse to sign this AUTHORIZATION, Oceanside Chiropractic, LLC will not refuse to provide treatment however, it will not be possible for Oceanside Chiropractic, LLC to file third party billing on my behalf and I will be responsible for 1) payment in full at the time services are provided to me 2) scheduling my own appointments since Oceanside Chiropractic, LLC will be unable to contact me 3) all contact with Oceanside Chiropractic, LLC regarding my care. *Additionally, any collection activity as permitted by law is not waived by refusal to sign the authorization.*

I have the right to inspect or copy, within boundaries, the protected health information to be used/disclosed. A reasonable fee for copying will apply. A copy of the signed authorization will be provided to me.

HEALTHCARE AUTHORIZATION

I have read and understand this Healthcare Authorization Form and acknowledge receipt of The Notice of Privacy Practices for Protected Health Information. My signature below represents agreement with these practices.

DOB:_____

Patient's name (please print): _____

Patient's Signature: _____

Today's Date: _____

Name of Personal Representative (if someone is designated to act on your behalf/or for a minor)

Parent or Personal Representative name (please print):_____

Signature:_____

Description of Representative's Authority to Act on Patient's Behalf:_____

Oceanside Chiropractic

OFFICE POLICY

1. Patients at Oceanside Chiropractic are seen by appointment. Patients may call the office at **401-757-0408** and schedule an appointment. Walk Ins will be seen when an appointment is available.

2. Oceanside Chiropractic, LLC reserves the right to charge a missed appointment fee of **$25** for any appointment missed without a phone call cancellation. It is always best to call to cancel or reschedule your appointment to avoid this fee.

3. If you have a scheduled appointment and know you will not be making it on time, please give us a call prior to your appointment so we can give other patients your time slot and can verify if your new time is available.

4. Office hours are as follows:

Monday, Wednesday, Thursday	9 AM -12:30 PM 3 PM- 6:00 PM
Tuesday	3 PM – 6 PM
Friday	9 AM – 12:30 PM

5. Oceanside Chiropractic does offer Emergency visits during off hours for an additional fee of **$50** for existing patients and **$100** for new patients.
   For an Emergency visit:
   Email drheather.oceanside@gmail.com or send a message on FaceBook

6. Payment is due at the time of service. We accept cash, check, and credit card.

7. Please notify Dr. Heather if you are in an automobile accident before your adjustment. Additional exams may need to be performed prior to your adjustment for your safety.

8. Oceanside Chiropractic is **not** a participating provider with any insurance companies. We can call and verify any out of network benefits you may have through your insurance company. Please provide the front desk with your insurance card so we may verify these benefits for you. Dr. Heather is also a non- participating provider with Medicare. Medicare will directly reimburse you, the patient. Please provide the front desk with your Medicare card. Oceanside Chiropractic **does** accept automobile insurance for our current patients if you have been in an accident. Please notify the front desk if you have been in an auto accident.

9. Oceanside Chiropractic will be closed on the following Holidays: New Years Eve/Day, Christmas Eve/Day, Memorial Day, 4th of July, Labor Day, and Thanksgiving. Patients will be given advanced noticed of any office closures.

10. Oceanside Chiropractic may close for inclement weather. Patients who are on the schedule will receive phone calls for cancellation when possible. If you do not have an appointment, please check our Facebook page www.facebook.com/oceansidechiropracticwesterly for office closures and announcements.

11. Please 'Like' our Facebook Page www.facebook.com/oceansidechiropracticwesterly for additional health information, promotions and announcements.

12. Further office information may also be found at out website www.oceansidechiropractic.net

I have read and understand the above statements.

Patient/Guardian
Signature:_____Date:_____