

# Pediatric Intake & History



## Patient Information

Patient Name \_\_\_\_\_  
Address \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone: \_\_\_\_\_  
Cell Phone: \_\_\_\_\_  
Email: \_\_\_\_\_  
Sex:  M  F Age: \_\_\_\_\_ Birthday: \_\_\_\_\_

### IN CASE OF EMERGENCY, PLEASE CONTACT:

Name \_\_\_\_\_  
Relationship \_\_\_\_\_  
Contact Number \_\_\_\_\_

Mother's Name: \_\_\_\_\_  
Mother's Occupation: \_\_\_\_\_  
Mother's Phone: \_\_\_\_\_  
Mother's Email: \_\_\_\_\_

Father's Name: \_\_\_\_\_  
Father's Occupation: \_\_\_\_\_  
Father's Phone: \_\_\_\_\_  
Father's Email: \_\_\_\_\_

Who may we thank for referring you? \_\_\_\_\_  
Has your child been to a chiropractor before? \_\_\_\_\_

## How Can We Help Your Child?

Wellness Checkup  Other: \_\_\_\_\_

If your child is already experiencing a symptom, please describe it: \_\_\_\_\_

Has your child been treated on an emergency basis?  Yes  No

Please describe: \_\_\_\_\_

## Pregnancy History

Did you experience any complications during your pregnancy? (check all that apply)

- Back/Other Pain  Gestational Diabetes  Pre/Eclampsia  Strep B  
 Pre-Term  Fatigue  Swelling  Nausea/Vomiting

Other (Please Describe): \_\_\_\_\_

## Birth History

Type of birth (check all that apply):

- Hospital  Birth Center  Normal/Vaginal  Home  Breech  
 Cesarean  Scheduled/Induced  Epidural  Pitocin  Dr. Assisted

Problems during labor/delivery? \_\_\_\_\_

- Antibiotics  Failure to Thrive  Meconium  Jaundice  Congenital Abnormalities  
 Respiratory Distress  Extended Hospitalization  Other: \_\_\_\_\_

## Growth & Development

Infant feeding:  Breast  Bottle  Formula

Number of hours of sleep each night: \_\_\_\_\_ Quality of sleep : \_\_\_\_\_

At what age did the child: \_\_\_\_\_

Respond to sound: \_\_\_\_\_ Crawl: \_\_\_\_\_ Hold head up: \_\_\_\_\_

Stand: \_\_\_\_\_ Sit unsupported: \_\_\_\_\_ Walk unsupported: \_\_\_\_\_

## Childhood Diseases, Illnesses & Vaccinations

Has your child had (check all that apply)?:

Chicken Pox

Measles

Rubeola

Mumps

Rubella

Pertussis/Whooping Cough

Has your child ever suffered from (check all that apply)?:

- |  |   |   |  |  |
|--|---|---|--|--|
| <input type="checkbox"/> Allergies           | <input type="checkbox"/> Broken Bones         | <input type="checkbox"/> Digestive Issues | <input type="checkbox"/> Hypertension    | <input type="checkbox"/> Orthopedic Problems |
| <input type="checkbox"/> Anemia              | <input type="checkbox"/> Chronic Ear Aches    | (Constipation/diarrhea)                   | <input type="checkbox"/> Scoliosis       | <input type="checkbox"/> Paralysis           |
| <input type="checkbox"/> Arm Problems        | <input type="checkbox"/> Colds/Flu            | <input type="checkbox"/> Dizziness        | <input type="checkbox"/> Shoulder Issues | <input type="checkbox"/> Poor Appetite       |
| <input type="checkbox"/> Asthma              | <input type="checkbox"/> Colic                | <input type="checkbox"/> Fainting         | <input type="checkbox"/> Stroke          | <input type="checkbox"/> Ruptures/Hernias    |
| <input type="checkbox"/> Back Aches          | <input type="checkbox"/> Convulsions/Seizures | <input type="checkbox"/> Headaches        | <input type="checkbox"/> TMJ Issues      | <input type="checkbox"/> Sinus Trouble       |
| <input type="checkbox"/> Bed Wetting         | <input type="checkbox"/> Delayed Speech       | <input type="checkbox"/> Heart Trouble    | <input type="checkbox"/> Urinary Issues  | <input type="checkbox"/> Tuberculosis        |
| <input type="checkbox"/> Behavioral Problems | <input type="checkbox"/> Diabetes             | <input type="checkbox"/> Hyperactivity    | <input type="checkbox"/> Osteoporosis    | <input type="checkbox"/> Walking Problems    |

Have you vaccinated your child?

- No  Yes  As Scheduled  Delayed Schedule

## Allergies, Medications, Surgeries, & Family History

Allergies (list): \_\_\_\_\_

Medications (list): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Surgeries (list): \_\_\_\_\_

Family History (list): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## Siblings

How many children do you have? \_\_\_\_\_

Number of pregnancies: \_\_\_\_\_

Children's ages: \_\_\_\_\_

Are you currently pregnant?  No  Yes, I am Due: \_\_\_\_\_

Children's health concerns: \_\_\_\_\_

Health concerns regarding this pregnancy? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## Authorization for Care

I hereby authorize the Doctor to work with my condition through the use of adjustments to my spine, as he or she deems appropriate. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I agree that I am responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand that if I suspend or terminate my care, any fees for professional services rendered me will become immediately due and payable.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in collecting from the insurance company.

**Ownership of X-ray Films:** It is understood and agreed that the payments to the Doctor for X-rays is for examination of X-rays only. The X-ray negative will remain the property of the office. They are kept on file where they may be seen at any time while I am a patient at this office.

SIGNATURE:	DATE:
GUARDIAN OR SPOUSE AUTHORIZING CARE SIGNATURE:	DATE:

WHO SHOULD RECEIVE BILLS FOR PAYMENT ON YOUR ACCOUNT?

- PATIENT   
  SPOUSE   
  PARENT   
  WORKERS COMP   
  AUTO INSURANCE   
  MEDICARE   
  HEALTH INSURANCE

## Notice of Privacy Policy

Protecting the privacy of your personal health information is important to us. 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 your disclosures.
- You may inspect and receive copies of your records within 30 days with a request.
- You may request to view changes to your records.
- In the future, we may contact you for appointment reminders, announcements and to inform you about our practice and its staff.

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

- Conduct, plan and direct my treatment and follow up with multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician's certifications.

I have read and understand your Notice of Privacy Practices. A more complete description can be requested. I also understand that I can request, in writing, that you restrict how my personal information is used and or disclosed.

PATIENT NAME (PLEASE PRINT):	RELATIONSHIP TO PATIENT:
SIGNATURE:	DATE:

## Photo and Video Permission

I give Family First Chiropractic Wellness Center permission to take pictures and videos of me \_\_\_\_\_  
 I am aware that the photos and videos taken may be used in office promotion, fliers, social networks, such as facebook or twitter and/or website www.ffcwc.com. Videos will be used for training purposes only.

SIGNATURE:	DATE:
GUARDIAN OR SPOUSE AUTHORIZING CARE SIGNATURE:	DATE:

## What FFCWC is all about...

**Our Vision:** It is our vision that every man, woman, and child be checked regularly for subluxation throughout their lives.

**Our Mission:** It is our mission to educate and adjust as many families as possible toward optimal expression of life, utilizing the principles and paradigm of chiropractic to empower you to take control of your health.

**Our Purpose:** To provide the best opportunity for members of our community to live long, healthy, happy lives from their first breath to the last so they can fully engage in life and provide value to their families and community.

**Our Premise:** Families that are in our office are more equipped to handle the stress of everyday life.

### **Our Core Values**

**Passion:** We have a passion for service, life, and chiropractic.

**Professionalism:** We exhibit the skill, judgment, and behavior that is expected from a person who is trained to do a job well.

**Teamwork:** Our team works together by combining each of our unique strengths to create an environment that allows us to provide outstanding value to our community in a very simple and efficient way.

**Love:** Our service to our community is rooted by an unselfish and compassionate concern for the good of each individual we care for.

**Authenticity:** Each member of our team behaves in a manner that allows them to stay true to one's own personality, spirit, and character.

**Integrity:** We adhere to a code of having high moral values when serving and communicating the chiropractic paradigm to the world.

**Simplicity:** We act efficiently and communicate in a way that is easy to understand. We are experts at simplifying the complex.