Pediatric Intake & History

Family First Chiropractic Wellness Center

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 ☐ Experiencing a symptom (please describe it):_____
_____
_____
What have you tried so far: _____
_____
Has your child been treated on an emergency basis? ☐ Yes ☐ No Date(s): _____
_____
Health goals for your child: _____
_____

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/Transverse/Sunny
☐ 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 ☐ Latching Issues ☐ Doesn't Feed Well on One Side

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 Symptoms, Illnesses & Vaccinations

Has your child experienced any of these infections (circle all that apply)?:

Chicken Pox Measles Tuberculosis RSV Rubeola

Mumps Rubella Pertussis/Whooping Cough Covid Pneumonia

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

- ☐ ADD/ADHD Diagnosis
- ☐ Anxiety
- ☐ Anemia
- ☐ Asthma/Allergies
- ☐ Autism Diagnosis
- ☐ Back/Neck Aches
- ☐ Bed Wetting (x/wk___)
- ☐ Behavioral Problems
- ☐ Broken Bones
- ☐ Chronic Ear Aches (#___)
- ☐ Colds/Flu Frequently
- ☐ Colic
- ☐ Convulsions/Seizures
- ☐ Delayed Speech
- ☐ Depression
- ☐ Diabetes (T1/T2)
- ☐ Digestive Issues (Constipation/Diarrhea/Reflux)
- ☐ Dizziness/Fainting
- ☐ Headaches (x/wk___)
- ☐ Heart Trouble
- ☐ Hypertension
- ☐ Hyperactivity
- ☐ Menstrual Issues
- ☐ Night Terrors
- ☐ Orthopedic Problems
- ☐ PANDAS/ODD Diagnosis
- ☐ Paralysis
- ☐ Poor Appetite
- ☐ Ruptures/ Hernias
- ☐ Scoliosis
- ☐ Sinus Trouble
- ☐ Sleeping Issues
- ☐ SPD/ Sensory Troubles
- ☐ Stroke
- ☐ TMJ Issues
- ☐ Urinary Issues
- ☐ Walking/Crawling Problems

Have you vaccinated your child?

☐ No ☐ Yes ☐ As Scheduled ☐ Delayed Schedule ☐ Covid Vax

Allergies, Medications, Surgeries, & Family History

Allergies (List with Reaction): _____

_____

_____

Medications (List): _____

_____

_____

Surgeries (List Type & Appx. Date): _____

_____

_____

Family History (List): _____

_____

_____

Siblings

How many children do you (parent) have? _____

Children's ages: _____

Children's health concerns: _____

_____

Number of pregnancies: _____

Are you currently pregnant? ☐No ☐Yes, I am Due: _____

Health concerns regarding this pregnancy? _____

_____

Family First Chiropractic Wellness Center

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 and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt.

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

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:

Family First Chiropractic Wellness Center

Photo and Video Permission

Family First Chiropractic Wellness Center takes pictures and videos for clinical and training purposes. I give Family First Chiropractic Wellness Center permission to take additional photos and videos of my child _____ that may be used in office promotion, fliers, social networks, such as Facebook, Instagram or Twitter and/or the website www.ffcwc.com.

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

What FFCWC is all about...

Our Vision: It is our vision that every family seek chiropractic care as their first thought, first stop on their health journey.

Our Mission: It is our mission to support and adjust families towards optimal expression of life, utilizing the principles of chiropractic to empower them to take control of their 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

Family: We create a supportive atmosphere where we all feel cared for & can grow while building relationships.

Support: We listen to our patients to better understand their unique situation so we can provide the care and resources to empower them to build better health.

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 is encouraged to stay true to their 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.