

Date: ___/___/___

Pediatric Intake Form (Birth-9 years)

It is a pleasure to welcome you to our family of happy and healthy Chiropractic practice members. Many types of stressors (physical, mental, and chemical) can interfere with your child's growing brains, spine and nervous system. To help us serve you better, please complete the following information. We look forward to working with you to build better health for your family.

Child's Name _____ Date of Birth ___/___/___ Age _____ Male/Female
Parent/Guardian(s): _____
Address _____ City _____ State _____ Zip _____
Cell _____ Home _____ Email Address _____
Number of Siblings _____ Names, Ages, & Gender _____
Who may we thank for referring you? _____

Emergency Contact

Please list the name of someone we can call in case of emergency – We will first attempt to contact parent/guardian(s) listed above but would like a secondary in the event we are unable to reach them.

Name of Emergency Contact: _____

Relationship of contact to child: _____

Phone number(s) for contact: _____

Preferred Hospital: GUNDERSEN MAYO OTHER: _____

List the Main Health Concerns that Brought You into this Office

1) _____ 2) _____ 3) _____ 4) _____

Maintain Wellness

Please Check Any Issues Your Child Has Had in the Past or Currently Have:

___ Ear infections	___ Colic	___ Seizures	___ Sleep Problems
___ Chronic Colds	___ Headaches	___ Autism	___ Bed Wetting
___ Recurring Fevers	___ ADHD/ADD	___ Sensory Problems	___ Growing Pains
___ Allergies	___ Temper Tantrums	___ Digestive Problems	___ Asthma

Other Health Concerns: _____

Child's Name: _____ Date: ___/___/___

Health History

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)

Did your child have a fall similar to what was described above? Y/N Explain: _____

Has your child been involved in any sports? Y/N List: _____

Has your child been seen by a physician on an emergency basis? Y/N Explain: _____

List any surgical operations & years _____

Other traumas not described above? _____

of Doses of Antibiotics your child has taken: Past 6 months _____ Total Lifetime _____

Present prescription drugs/dosage? _____

Past prescription drugs/dosage? _____

Over the counter drugs (Tylenol, Cough syrup, Laxatives, etc.) _____

Name of Pediatrician: _____ Last Visit: ___/___/___

Pregnancy History

Name of Obstetrician/Midwife: _____

Complications during Pregnancy or Delivery? Y/N If yes, explain: _____

Ultrasounds during Pregnancy? Y/N If yes, how many? _____

Medications taken during Pregnancy/ Delivery? Y/N List: _____

Cigarette/Alcohol use during Pregnancy? Y/N

Location of Birth: Hospital Birth Center Home Birth

Intervention: Forceps Vacuum Extraction Caesarian Section

If Caesarian Section, was it: Emergency Planned

Genetic disorders/ disabilities? Y/N List: _____

Birth Weight: _____ Birth Length: _____ APGAR Scores: _____ - _____

Feeding History

Breast Fed: Y/N How long? _____ Formula Fed: Y/N How long? _____ Type: _____

Introduced to: Solid Foods @ _____ months Cow's milk @ _____ months

Food/Juice Allergies or Intolerances: Y/N List: _____

Developmental History

Your child's spine is most vulnerable to stress and should routinely be checked by a Doctor of Chiropractic for prevention and early detection of Vertebral Subluxation (Spinal Nerve Interference).

At what age was your child able to:

_____ Respond to stimuli _____ Cross Crawl _____ Stand Alone
_____ Respond to visual stimuli _____ Hold Head Up _____ Walk Alone
_____ Sit up

Lifestyle

Does your child:

- Eat health foods (organic products, etc.)
- Drink water
- Take vitamins - Type: _____
- Take probiotics

Exercise: None Moderate Daily Heavy

Hobbies/interests: _____

Is there anything else you would like us to know about your child? _____

Notice of Privacy Practices Acknowledgement

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

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

I acknowledge that I may request your NOTICE OF PRIVACY PRACTICES containing a more complete description of the uses and disclosures of my health information. I also understand that I may request, in writing, that you restrict how my private information is used to disclose to carry out treatment, payment, or healthcare operation. I also understand you are not required to agree to my requested restrictions, but if you agree, then you are bound to abide by such restrictions.

Parent/Guardian Signature: _____ Date: _____

Image & Testimonial Release

On occasion we will ask to take photographs, videos, or other recordings at True North during regular business hours or at after hour events. We love to capture the health and healing that is happening here for further community education, and to spread hope to others who may be dealing with similar situations to yours. The media that we capture may be used for things such as, but not limited to, advertising, educational materials, or social media. By signing below, you authorize us to use your image, or that of your family members that visit the True North office or events. You agree that your statements were given freely without coercion or incentive. Any photos or stories can be reviewed for accuracy at any time and you may revoke the use of your image with 30 days written notice in writing.

Parent/Guardian Signature: _____ Date: _____

Informed Consent for Chiropractic Care

Chiropractic care, like all forms of health care, while offering considerable benefits may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases, injury has been associated with Chiropractic care. The types of complications that have been reported secondary to Chiropractic care include: sprain/strain injuries, irritation of a disc condition, and rarely, fractures. One of the rarest complications associated with Chiropractic care occurring at a rate between one instance per one million to one instance per two million cervical spine (neck) adjustments may be a vertebral injury that could lead to a stroke.

Prior to receiving Chiropractic care in the Chiropractic office, a health history and physical examination will be completed. These procedures are performed to assess your specific conditions, your overall health and in particular your spinal health. These procedures will assist us in determining if Chiropractic care is needed, or if any further examinations or studies are needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan prior to beginning care.

- I understand and accept that there are risks associated with Chiropractic care and give consent to the examination that the doctor deems necessary and the Chiropractic care, including spinal adjustments, as reported following my assessment.
- I agree that a photocopy of this form may be used in place of the original. All professional services rendered are charged to the practice member. It is customary to pay for services when rendered unless other arrangements have been made in advance. I understand that I am financially responsible for charges not covered by this assignment.

The risks associated with exposure to ionization and spinal adjustments have been explained to me to my complete satisfaction, and I have conveyed my understanding of these risks to the Doctor. After careful consideration, I do hereby request and authorize imaging studies and Chiropractic adjustments for the benefit of my minor child for whom I have the legal right to select and authorize health care services on behalf of.

Under the Terms and Conditions of my divorce, separation or other legal authorization, the consent of a spouse/former spouse or other guardian is not required. If my authority to so select and authorize this care should change in any way, I will immediately notify this office.

Parent/Guardian Signature: _____ Date: _____

X-Ray Authorization

As your healthcare provider, we are legally responsible for your child's Chiropractic records. If it is necessary to take x-rays, we must maintain a record of your child's x-rays in our files. At your request, we will provide you with a copy of your child's x-rays in our files. The fee for copying x-rays on a disc is \$15. This fee must be paid in advance. Digital x-rays on a CD will be available within 72 hours of pre-payment during regular practice hours. Please Note: X-rays are utilized in this office to help locate and analyze vertebral subluxations. The Doctors of True North Chiropractic do not diagnose or treat medical conditions; however, if any abnormalities are found, we will bring it to your attention so that you can seek proper medical advice. By signing below, you are agreeing to the above terms and conditions.

Parent/Guardian Signature: _____ Date: _____