Children's Intake Form

Today's Date:_____

Child's Name: _____ Age: _____ Birth Date: _____ Gender: ☐ M ☐ F

Address:_____ City/State/Zip: _____

Parents' Names: _____ Parent's E-mail Address:_____

Parent's Cell Phone: _____ Parent's Office Phone: _____

Parent's Occupation: _____ Siblings Names & Ages: _____

Would you like to receive e-mail or text message reminders? (circle one) E-mail / Text Cell phone carrier: _____

Has your child ever seen a chiropractor before? ☐ Yes ☐ No If yes, what was the reason? _____

Chiropractor's Name: _____ Date of approximate last visit: _____

Name of OB/Gyn or Midwife: _____ Name of Pediatrician: _____

How were you referred to this office? _____

Reason For This Visit

Describe the purpose for this visit: _____

Is this problem: ☐ Occasional ☐ Frequent ☐ Constant

What makes this problem better? _____ What makes this problem worse? _____

Is the purpose of this appointment related to:

☐ Wellness check-up ☐ Birth trauma ☐ Sports ☐ Auto ☐ Fall ☐ Home injury ☐ Chronic discomfort ☐ Other

Please explain: _____

How did this condition start? ☐ Suddenly ☐ Gradually ☐ Post Injury

Has this condition: ☐ Gotten Worse ☐ Stayed Constant ☐ Come and Gone

Does this condition interfere with: ☐ Sleep ☐ Daily Routine ☐ Eating ☐ Other Activities

Please explain: _____

Has this condition occurred before? ☐ Yes ☐ No Have you seen other doctors for this condition? ☐ Yes ☐ No

Doctor's Name and Specialty: _____ Type of Treatment/Testing: _____

LiveFree CHIROPRACTIC

Health Conditions

□ Acid Reflux	□ Ear Infections	□ Back Pain	□ Neck Pain	□ Urinary Problems
□ Bed Wetting	□ Allergies	□ Poor Coordination	□ Sore Throats	□ Asthma
□ Constipation/Diarrhea	□ Recurrent Colds/Flu	□ Learning Disorders	□ Colic	□ Heart Murmurs
□ Headaches/Migraines	□ Bronchitis	□ Hyperactivity	□ Sleeping Difficulties	□ Fevers
□ ADD/ADHD	□ Scoliosis	□ Autism Spectrum	□ Excessive Fussiness	□ Latching Issues

Please list any other symptoms your child has experienced:

_____

What changes (if any) would you like to see accomplished in your child's health and/or behavior?

_____

Birth History

During pregnancy, did the mother…

☐ Take any medication ☐ Smoke or consume alcohol ☐ Experience any illness ☐ Suffer any trauma, falls, accidents

If yes to any of the above, please explain: _____

What type of exercise (if any) did mother do while pregnant? _____

Location of Birth: ☐ Home ☐ Birth Center ☐ Hospital What was the baby's gestational age at birth? _____

Describe the labor (check all that apply):

☐ Vaginal Delivery ☐ C-section Delivery ☐ Chemically Induced ☐ Premature Delivery ☐ Drug free

☐ Vacuum Extraction/Forceps ☐ Doctor pulled or twisted the baby's head

How long was active labor? _____ How long was the 2nd stage (pushing phase) of labor? _____

Describe any complications experienced during labor/delivery: _____

Did your child show any of these signs of birth trauma?

☐ Bruising ☐ Respiratory Distress ☐ Odd shaped head ☐ Stuck in birth canal ☐ Cord around neck

☐ Lack of use of one arm ☐ Head rotated to one side ☐ Excessively long birth

Birth Weight: _____Birth Height: _____ APGAR Score at 1 min: _____ at 10 min. _____

Growth & Development

Do/Did you breastfeed the baby? ☐ Yes ☐ No If yes, how long? _____

Does/Did you have any difficulty with latching or lactation? ☐ Yes ☐ No

Does/Did your child favor one side while nursing? ☐ Yes ☐ No If yes, which side? ☐ Right ☐ Left

Does/Did your child *lean* his/her head to one side? ☐ Yes ☐ No If yes, which side? ☐ Right ☐ Left

Does/Did your child *rotate* his/her head to one side? ☐ Yes ☐ No If yes, which side? ☐ Right ☐ Left

Do/Did you formula feed the baby? ☐ Yes ☐ No If yes, how long? _____ Formula given: _____

At what age did your child:

Hold up head _____ Sit alone _____ Crawl _____ Walk _____ Vocalize _____

At what age did you introduce solids? _____ Cow's milk or other milk alternative? _____

Are you aware of any food allergies, sensitivities, or intolerances? _____

Has your child ever taken antibiotics? ☐ Yes ☐ No If yes, how many times? _____ Why? _____

Has your child ever been hospitalized? ☐ Yes ☐ No Please explain: _____

Has your child ever fallen head first from a high place during the first year of life? ☐ Yes ☐ No

Please explain: _____

Has your child ever been in a car accident? ☐ Yes ☐ No Has your child ever had surgery? ☐ Yes ☐ No

Please explain: _____

Has your child ever had an adverse vaccine reaction? ☐ Yes ☐ No ☐ N/A

If "Yes" please describe: _____

List prescription medication or supplements taken: _____

List any allergies your child has: _____

I, being parent or legal guardian of this minor, authorize, request, and direct the doctor to perform any examination and chiropractic care that she deems necessary.

Guardian's Signature: _____ ***Date:*** _____

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 Live Free Chiropractic to use and/or disclose Protected Health Information in accordance with the following:

SPECIFIC AUTHORIZATIONS:

- I give permission to Live Free Chiropractic 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 Live Free Chiropractic contacts me by phone, I give them permission to leave a phone message on my answering machine or voicemail.

- I give permission to Live Free Chiropractic to use my name on a welcome and birthday board.

- I give permission to Live Free Chiropractic 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 Live Free Chiropractic 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 Live Free Chiropractic 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 Live Free Chiropractic 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 Live Free Chiropractic plus 7 years or until revoked by me.

(over)

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 Live Free Chiropractic. 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 Live Free Chiropractic 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, Live Free Chiropractic will not refuse to provide treatment however, it will not be possible for Live Free Chiropractic 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 Live Free Chiropractic will be unable to contact me 3) all contact with Live Free Chiropractic 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.

SSN: 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: _____

Office Policies

1. We value your time and will always do our best to see you at your scheduled appointment time. We hope that you will extend the same courtesy to us. If you are unable to keep a scheduled appointment, kindly give 24 hours notification.

2. We understand that unexpected events occur that will cause you to miss an appointment without notification. After the 2nd occurrence you will be charged $25 for any missed appointment.

3. Payments are due at the time the service(s) is rendered. This office may make financial arrangements on an individual basis and will remain confidential. Any such plan or arrangement will be discussed in private.

4. This office does not participate with any insurance companies. If you wish to submit insurance claims, ask the front desk to print a super bill. The patient is responsible for submitting claims to insurance companies for reimbursement. This office is not liable for any unpaid claims by the insurance company.

5. This office accepts all major credit cards, cash, and personal checks.

6. I hereby give permission to Live Free Chiropractic to use my name and photographic likeness. Photos may be used for print, web or digital reproduction and for commercial and/or editorial use, including (but not limited to) advertising/promotion via social media, newsletters, and/or printer material relevant to Live Free Chiropractic. I seek no compensation for the use of these photographs.

I have read and understand the Office Policies and agree to abide by these terms.

_____ _____

Patient/Guardian Signature ***Date***