Child Intake Form (Birth-18 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_____ Gender: Male/Female
Preferred Name/Nickname_____ Date of Birth____/_____/_____ Age_____
Parent/Guardian(s): _____
Primary Phone _____ Cell/Home/Work Secondary Phone _____ Cell/Home/Work
Email Address _____
Address_____City_____State_____Zip_____
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 the 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) _____

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 or issues you would like us to know:

_____

_____

_____

What are your Top 3 Health Goals for your child?:

1)

2)

3)

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.)* _____

Have you chosen to vaccinate your child? Yes, on schedule Yes, on a modified schedule No

If yes, any reactions to the vaccines?: _____

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

Pregnancy History

Name of Obstetrician/Midwife:_____

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

_____

Any fertility issues? Y/N If yes, please explain:

_____

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

Medications taken or vaccinations during Pregnancy/ Delivery? Y/N

List:_____

Any illnesses during Pregnancy? Y/N If yes, please explain:

_____

Any notable physical or emotional distress during Pregnancy? Y/N If yes, please explain:

_____

Cigarette/Alcohol use during Pregnancy? Y/N

Location of Birth: ☐ Hospital ☐ Birth Center ☐ Home Birth

Intervention: ☐ Forceps ☐ Vacuum Extraction ☐ Cesarean Section

If Cesarean 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
Does/did your child struggle with colic, reflux, or constipation as an infant?_____
Allergies or Intolerances (food, medication, environmental, etc): Y/N
If yes, please list and note when they started:_____
_____

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 sound _____ Cross Crawl _____ Stand Alone
_____ Follow an object with eyes _____ Hold Head Up _____ Walk Alone
_____ Sit up

Does your child have any social, emotional, or behavioral issues? Y/N
If yes, please explain:_____
Does your child struggle with night terrors or sleep issues? Y/N
If yes please explain:_____

Lifestyle

Does your child:

□ Eat health foods (organic products, whole foods, etc.) If not, what type of foods do they prefer to eat?:
_____
□ 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 and/or their health?
_____
_____
_____

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: _____

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: _____