PEDIATRIC INTAKE FORM (3-10 YEARS)

Name (first, middle, last) _____ Date _____

Phone Number: _____ E-Mail Address: _____

Address _____ City _____ State _____ Zip _____

Date of Birth: _____ Age: _____ Social Security Number: _____

Emergency Contact _____ Relationship _____ Phone_____

Name of Insured: _____ Birthdate: _____ SSN: _____

How did you hear about our clinic? _____

Have you ever had chiropractic care before? **Y N** Name of last chiropractor _____

REASON FOR VISIT

Please circle all that apply:

Wellness/Preventative Care Poor Posture Improved athletic performance

Area(s) of complaint: _____

When did the problem start? _____

Was this related to a fall or accident? **Y N** Please describe: _____

Describe the pain/problem: _____

Any other areas of concern? _____

If any of the following conditions have been experienced in the past, please mark with a **"P"** for past. If any of the following conditions are currently being experienced, please mark a **"C"**. Leave blank any that do not apply.

___Headaches	___Diarrhea	___Neck pain	___Nausea
___Ear infections	___Constipation	___Mid back pain	___Loss of appetite
___Allergies (seasonal)	___Bed-wetting	___Low back pain	___Frequent urination
___Allergies (food/other)	___Colic	___Knee pain	___Frequent thirst
___Sinusitis	___Asthma	___Ankle sprains	___Pain in leg
___Hyperactivity	___Indigestion	___Fatigue	___Mood disorder
___Difficulty sleeping	___Learning Difficulties/delays		

Sleep: **Good** **Bad** **Poor** **Other:** _____

Other conditions: _____

Current Medications (including over the counter): _____

HEALTH HISTORY

Birth:

Was the birth assisted? **Y** **N**

If yes, how? **Forceps** **Vacuum Extraction** **C-Section** **Induced Labor**

Duration of Birth: _____ Was the delivery normal? **Yes** **No**

Any complications at birth? _____

Did your child receive vaccinations? **Yes** **No** If yes, which ones? _____

Did your child react to them? **Yes** **No**

Development:

Does or did your child have any of the following (Please check all that apply):

Difficulty with crawling (on all fours)	Did not crawl on all fours
Difficulty learning to ride a bike	Appears clumsy
Difficulty learning to read	Difficulty writing
Difficulty using utensils	Difficulty buttoning clothing
Difficulty tying shoes	Difficult or awkward to walk/run
Poor hand-eye coordination	Difficulty sitting or paying attention

At what age did your child start to walk unassisted: _____

Neurological/Other:

Has your child ever been diagnosed by a medical professional with any of the following:

Hearing loss or impairment	Visual Impairment
Neurological disorders	Anxiety/Depression
Obsessive Compulsive Disorder	Autism/Autism Spectrum Disorder
ADD/ADHD	Tourette's Syndrome
Dyslexia	Other: _____

If yes, by whom? _____

General Activities (Check all that apply):

___heavy backpack (more than 15% of body weight)	___sleeps on stomach
___plays video games ____ hours/day	___exercise ____ hours/day
___soft drinks ____ drinks/day	___computer use ____ hours/day

List any sports/recreational activities: _____

Do you have any pets at home? **Y** **N**

Food:

Approximate consumption per day: Water _____ Milk _____ Soda/Other _____

Favorite foods list: _____

Is your child a picky eater? **Y** **N**

If yes, describe: _____

CONSENT TO EXAMINE, X-RAY, AND TREAT A MINOR

I, the parent or legal represntative of _____ authorize the performance of a diagnostic examination and x-rays of this child or which Leahy Chiropractic P.A. may consider necessary or advisable in the course of treatment.

_____ _____

HIPAA (HEALTH INSURANCE PORTABILITY ACCOUNTABILITY ACT)

Signature (Parent's Signature if Patient is a Minor) Date

Appointment Calls, Open Room Adjusting & Health Care Information

Dr. Leahy and members of the practice staff may need to use your name, address, phone number and your clinical records to contact you with appointment reminders, information about treatment alternatives or other health related information that may be of interest to you. If this contact is made by phone and you are not at home a message will be left on your answering machine or with a family member. By signing this form, you are giving us authorization to contact you with these reminders and information.

You can restrict the individuals or organizations to which your health care information is released or you may revoke your authorization to us at any time, however your revocation must be in writing and mailed to us at our office address. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. In addition, if you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

Information that we use or disclose based on authorization you are giving us may be subject to re-disclosure by anyone who has access to the reminder or other information and may no longer be protected by the federal privacy rules.

You have the right to refuse to give us this authorization. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

We offer spinal adjustments in an open room style with other patients in the same room. Occasionally comments about your symptoms, improvement or lack thereof may be discussed at your office visits.

You may inspect or copy the information that we used to contact you to provide appointment reminders, information about treatment alternatives, or other health related information at any time (#164.524).

This notice is effective as of _____, 20_____. This authorization will expire seven years after the date in which you last received services from us.

I authorize you to use or disclose my health information in the manner described above. I also understand that I may receive a copy of this form when needed.

Patient Signature _____ Date _____