# 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_____

## What are the top 3 goals or reasons for seeking care:

1._____

2._____

3._____

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

**Sleep:** **Good** **Bad** **Poor**

Current Medications (including over the counter): _____

**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, scoot, army crawl)
__Difficulty learning to ride a bike
__Difficulty learning to read
__Difficulty using utensils
__Difficulty tying shoes
__Poor hand-eye coordination
__Skipped milestone: Roll, Sit, Crawl, Stand, or Walk
__Appears clumsy
__Difficulty writing
__Difficulty buttoning clothing
__Difficult or awkward to walk/run
__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:

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

**If yes, by whom?** _____

**General Activities** (Check all that apply)**:**

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

**Bowel Movements** (Check all that apply)

___Enormous bowel movements
___Diarrhea **and** constipation
___Don't know, don't go in with him/her anymore
___Mucus in the stools
___Sticky stools, or child has trouble cleaning self after BM, uses too much paper
___Undigested food present in stools
___Sandy or gritty-looking stools
___Spotting of feces in underwear

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: _____

**Please continue on to next page to sign patient consent and hippa.**

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

I, the parent or legal representative 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.

_____ _____

Parent/Guardian Signature Date

# HIPAA (HEALTH INSURANCE PORTABILITY ACCOUNTABILITY ACT)

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 _____