Pediatric Intake Form

Patient Information

Date_____

First Name_____ MI_____ Last Name_____

Birthdate_____ Age_____ Gender_____

Address_____

City/State/Zip_____

Phone number_____ Email _____

Parent/Guardian's Name_____

Best number to contact you at:_____

Pediatrician's Name_____ Clinic_____

Present Health Challenge(s)

What brings you/child into the office today?_____

When did it begin? _____ Is it Better/Worse/The Same?

Does anything make it better? _____ Does anything make it worse? _____

Does it affect the child's daily activity? Yes/No If yes, how so _____

Is your child being seen by another healthcare professional for this? Who? _____

Types of treatment _____

List any and all concerns for your child's health and whether or not you feel it is related to your child's current health complaint(s) _____

Please select all that apply:

____ Allergies	____Frequent colds/ congestion	____Upper respiratory Infections	____Asthma
____Ear infections	____Infected/sore Throat	____Tonsillitis	____Laryngitis
____Colic	____Reflux/spitting up	____U-tract infections	____Poor appetite
____Poor digestion (constipation/diarrhea)	____Thrush mouth/ chronic diaper rash	____Eczema/psoriasis/ Other skin rashes	____ADD/ADHD
____Irregular sleep patterns	____Night terrors	_____Bed wetting	____Headache
____Anxiety	____Mood swings	____Bruising	____Vision problems

Please list any and all traumas/injuries/falls experienced by your child, how they occurred and what was done to correct them _____

_____

Please list all activities/sports your child is in _____
Quality of child's sleep_____ Number of hours of sleep___ Sleep position: side/back/stomach
Anything else we should know about your child _____

How would you rate your child's diet/nutrition? ☐Good ☐Fair ☐Poor
Does your child take vitamins or supplements? Yes/No If yes, please list _____
List all medications: _____
Does your child have any food or other allergies? _____
Beverage(s) most consumed_____ Water consumed _____ ounces/day

Prenatal History

Is your child adopted? Yes/No
Did you smoke/consume alcohol? Yes/No Did you take any medications_____
Number of ultrasounds _____ Any pregnancy complications_____

Birth History

Place of birth_____ Provider_____
Type of birth ☐ Vaginal ☐ C-section Was labor induced? Yes/No Why?_____
Pain medication used_____
Birth trauma (circle one) Doctor assisted/twisting or pulling/vacuum extraction/forceps
APGAR score: at birth_____/10 at5 minutes_____/10
Did your child have a misshaped skull/head? Yes/No Purple markings on their face? Yes/No
Do you/did you breastfeed your child? Yes/No If yes, for how long?_____
Does your child prefer one breast/side over the other? Yes/No Side: Right/Left

Has your child been immunized according to the recommended schedule? Yes/No
Reason for vaccination ☐ Informed decision ☐ Recommended ☐ Didn't know I had a choice
Did your child have any negative reactions to vaccinations? Yes/No Please List _____
Has your child ever had any surgeries? Yes/No Please explain_____
Have they been on antibiotics? Yes/No How many times _____
Is your child currently taking any medications? Yes/No Please list_____

Goals for My Child's Care

Children see chiropractors for a variety of reasons. Your Doctor will weigh your needs and desires when recommending your child's chiropractic care program. Please check the type of care desired so that we may be guided by your wishes whenever possible.

____RELIEF CARE: symptomatic relief of pain or discomfort.
____CORRECTIVE CARE: Correcting and relieving the cause of the problem as well as the symptoms.
____WELLNESS CARE: Bring whatever is malfunctioning in the body to the highest state of health possible with chiropractic care, regardless if symptoms are present or not.

Authorization to treat a minor

I, _____, the parent or legal guardian of _____, a minor, hereby authorize Dr. Nicole Olson, the Doctor of Chiropractic in this office, and whomever she may designate as her assistant(s), to administer examinations, chiropractic care and treatment when deemed necessary. I understand and am informed that, just as in the practice of medicine, there are some risks to treatment and that results may vary depending on each individual patient, and I wish to rely on the doctor to exercise her judgment and expertise during the course of examination and treatment that is in my or my child's best interest.

I clearly understand and agree that all rendered are charged directly to me and that I am personally responsible for payment. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I understand that if my child's care is suspended or terminated, any fees for professional services rendered will become immediately due and payable.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and policy holder. I understand that the Doctor's office will prepare any necessary reports and forms to assist me in collecting from the insurance company and that any amount authorized to be paid directly to the Doctor's office will be credited to my account on receipt. I hereby authorize assignment of insurance right and benefits (if applicable) directly to the provider for services rendered to my child.

PATIENT (please print)_____ DOB____/____/____

PARENT/LEGAL GUARDIAN (please print) _____

Signature_____ Date____/____/____

☐ I request that my child may be able to maintain their chiropractic appointments without the presence of a parent/guardian when necessary. ***(This only applies to children 16 years of age and older.)***

Signature of parent/guardian_____ Date____/____/____

Witness signature_____ Date____/____/____

Emergency Contact

Name_____ Relationship_____

Work Phone _____ Home Phone _____

Patient Demographics Form for Insurance Patients

First Name: _____ **MI** _____ **Last Name** _____

Street Address: _____ City, State _____ Zip _____

Mailing Address (if different) _____ City, State _____ Zip _____

Social Security Number _____-_____-_____ Date of Birth _____/_____/_____

Home Phone _____ Work Phone _____

Cell Phone _____ Employed at _____

Email Address _____ Marital Status Married Single Divorced Widowed Separated Child

Spouse's Name _____ Employed at _____

Cell Phone _____ Work Phone _____

Emergency Notification Name _____ Relationship _____

Phone _____ Referring Doctor _____

Primary Insurance Company _____

Address _____

Policy # _____ Group # _____

Policy Holder (if different than above)_____

Social Security Number _____-_____-_____ Date of Birth _____/_____/_____

Effective Date _____ Employed at _____

Work Address _____ Work Phone _____

Secondary Insurance Company _____

Address _____

Policy # _____ Group # _____

Policy Holder (if different than above)_____

Social Security Number _____-_____-_____ Date of Birth _____/_____/_____

Effective Date _____ Employed at _____

Work Address _____ Work Phone _____

Please note any additional Insurance Coverage _____

I authorize the release of any medical or other information necessary to process this claim. I also authorize payment of medical benefits to be made directly to the physician or supplier of services rendered. Our office cannot accept responsibility for collecting an insurance claim or for negotiating disputed claims. You are responsible for payment within ninety (90) days from date of service. Insurance reimbursement is a contract between you and your insurance company. In consideration of the services rendered to me by this physician, I am obligated to pay said office in accordance with the physician's credit and policy terms.

Advance Beneficiary Notice (ABN)

Date: _____ Patient: _____

Insurance: _____

This is a notice that your insurance company may not pay for all of the services that you receive during your visit to our office.

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.

Supplies and Services	**Reason(s) Insurance May Not Pay**	**Estimated Cost**
Chiropractic exam visit, adjustments, or therapies	Not a covered expense Benefits exceeded	$30-$125

_____**YES,** I want to receive these services. If my insurance carrier denies payment, I am completely responsible for payment in full. I understand that I can appeal this decision for nonpayment by my insurance carrier.

_____**No,** I have decided not to receive these services.

By signing this notice, you have received and understand this notice. You agree to take financial responsibility for the cost of the supplies and services listed above should your insurance company deny coverage for the listed items.

Guarantor Signature: _____ Date: _____