



## Pediatric Intake Form

### Patient Information

Date \_\_\_\_\_  
 First Name \_\_\_\_\_ MI \_\_\_\_\_ Last Name \_\_\_\_\_  
 Birthdate \_\_\_\_\_ Age \_\_\_\_\_ Gender \_\_\_\_\_  
 Address \_\_\_\_\_  
 City/State/Zip \_\_\_\_\_  
 Parent/Guardian's Name \_\_\_\_\_  
 Phone number \_\_\_\_\_ Email \_\_\_\_\_  
 How did you hear about our clinic? \_\_\_\_\_ If a friend, who? \_\_\_\_\_  
 Insurance Company \_\_\_\_\_  
 Policy # \_\_\_\_\_ Group # \_\_\_\_\_  
 Policy Holder (if different from above) \_\_\_\_\_  
 Policy Holder's Date of Birth \_\_\_\_\_ Policy Holder Employed at \_\_\_\_\_

### 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

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**For pediatric patients age 5 or UNDER, please complete the next section:**

### **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: ☐ Doctor assisted: twisting or pulling out ☐ Vacuum extraction ☐ Forceps  
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 OR side over the other? Yes/No If so, which 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 \_\_\_\_\_

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### **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.

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### 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. Please ask the front desk for a different authorization form if a non-parent/non-guardian is to bring the minor.)***

Signature of parent/guardian \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

### Emergency Contact

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Work Phone \_\_\_\_\_ Home Phone \_\_\_\_\_

### Missed Appointment Policy

There is now the implementation of a no-show policy for missed appointments.

The first appointment going forward (from the date signed below) where a patient misses or calls to cancel an appointment without the proper **3 HOUR NOTICE** is waived. *Emergency situations will be determined and handled on a case by case basis.*

Every appointment thereafter where no **3 HOUR NOTICE** is given, a patient is charged \$25 (to be collected at the next visit). This policy is per person. For families, the charge will still be \$25 per person scheduled.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_



### 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: \_\_\_\_\_