PEDIATRIC INTAKE FORM (1-10 YR)

Today's Date:

Age of Child:

Male Female

PERSONAL INFORMATION

Child's Name: Parent/ Guardian Name(s):

Address, City, St Zip Code]:

Home phone: Cell phone: Work phone:

Email: Child's Birthday:

Who can we thank for referring you?

Is your child receiving care from any other health professional? Yes No If yes, please explain: _____

Is your child currently taking any medications/ natural supplementation? Yes No If yes, please explain: _____

HEALTH INFORMATION

What health concerns about your child brought you in today?

When did this condition begin? How did it start? Sudden Gradual Post- Injury What injury? _____

Has your child received care for this condition before? Yes No If yes, please explain: _____

Is this condition : Worse Improving Intermittent Constant Unsure

What makes this concern better? _____ What makes this concern worse? _____

Does your child have any allergies? Yes No If yes, please list them: _____

_____

List any vaccinations your child has received as well as any adverse reactions:

What are the top three health goals for your child?

1: _____

2: _____

3: _____

What are you looking for your child to gain from seeing a chiropractor?

- Resolve current issue
- Overall Wellness
- Both

Has your child experienced?

- Traumatic falls
- Digestion issues i.e. reflux, colic
- Bed Wetting
- Behavioral issues

HISTORY OF PREGNANCY

Did you carry full term? Yes No

If no, how long did you carry?

Have you been under regular Chiropractic care? Yes No

Please list any complications with your pregnancy:

_____

_____

Describe your experience: Labor duration: _____ Location of delivery: _____

Complications during labor: Yes No If yes, please explain: _____

Interventions used: _____

Fertility issues? Yes No If yes, please explain: _____

Did mother smoke? Yes No If yes, please explain: _____

Did mother Drink? Yes No If yes, please explain: _____

Did mother exercise? Yes No If yes, please explain: _____

Was mother ill? Yes No If yes, please explain: _____

HIPAA CONSENTS

Name of Practice : Kids Only Chiropractic

Address : 14462 S Redwood Road Bluffdale Ut 84065

Privacy Contact : Dr. Matthew Roller D.C.

Telephone : 801-290-8966

** I understand that I do not have to sign this authorization in order to receive treatment from this practice, but when my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule.

NOTICE OF PRIVACY PRACTICE RECEIPT:

I acknowledge that I was provided with the Notice of Privacy Practices of the Chiropractic Practice named at the top of this page.

Printed Name of Patient's parent or Guardian: X

Signature of Patient's parent or Guardiant: X

Date: X

Patient's Date of Birth: X

RELEASE AND CONSENTS

AUTHORIZATION TO TREAT A MINOR CHILD

I authorize Kids Only Chiropractic to provide care as deemed necessary by the doctors to my son/daughter

Child's Name:

Signature of Guardian: Date:

Informed Consent

Although Chiropractic is reported to be the safest health care system in the world, some say there are very slight risks associated with it. We feel that it is responsible to let you know:

- Risk of stroke is reported to be 1 in 5-8 million or so... and the cause has yet to be determined.
- While extremely rare, there have been reports of ligament sprains, and even rib fractures reported.
- There have been rare reports of disc injuries although no clinical scientific study has ever demonstrated chiropractic care to be the cause.

Chiropractic care has been proven to be both, clinically and very cost effective. The risk of injuries and complications is so small that chiropractors carry the lowest malpractice insurance premiums of all the health care professions in the world.

I have read and understand the above consent, and have had the opportunity to discuss it with my chiropractor. I consent to the care recommended by my chiropractor and extend this consent to include all doctors of this Chiropractic & Wellness Center. This consent applies to all present and future care for me and my family.

Patient Name _____ Date: _____

Patient/ Guardian Signature _____ Witness _____

- I hereby authorize Kids Only Chiropractic to release periodic status reports from the medical records of the patient listed below. The reports may be released to other physicians or facilities participating in my care.
- I understand my records are confidential and cannot be disclosed without my written authorization, except otherwise provided by law.
- I understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance upon it and that this authorization will automatically expire on one year from date signed.
- I understand that a photocopy or facsimile of this authorization is as valid as the original.
- I authorize the release of any medical billing or other information necessary to process claims on my behalf.
- I agree to be fully responsible for all lawful debts incurred by myself (or dependents under care) for services received from Kids Only Chiropractic.
- I agree that Kids Only Chiropractic can leave a detailed message by email, voicemail or to anyone answering my phone about my or my children's conditions or finances.

Patient / Guardian Signature _____ Date: _____

Print Name _____

Patient media Authorization release form (Optional)

Name Of Patients:

1) I authorize the health care professionals who treat me at "Kids Only Chiro" to release and discuss patient information about their treatment or my medical condition, or related topics, (or patient information about their treatment, the medical condition, or related topics, of my child or an individual to whom I provide guardianship.) No special favors, payment or other compensation have been promised to me for agreeing to the authorization. Finally, I understand that the patient information that is released will be current as of the time this authorization is signed and that, if additional information is needed at a later date, I may be asked to sign another Authorization release form.

2) I release Kids only chiropractic and it's spokespeople, from any and all state or federal laws relating to patient privacy.

3) I specifically authorize officials from Kis only chiropractic to share this health information (or that of a child, or an individual to whom I provide guardianship) with members of the news media.

4) I voluntarily give my permission for Kids Only Chiropractic staff to represent me (or my child or an individual to whom I provide guardianship) on video/audio tape, Photograph film or any other medium including social media.

5) I Authorize use of my (or my child or an individual to whom I provide guardianship) name, likeness, voice and biographical material in Kids only Chiropractic publications and website-to include electronic and printed magazines, brochures, newsletters and the internet and its social media (E.G., Facebook, twitter, etc.) - for publicity for the clinic and it's programs.

6) I give "Kids Only Chiropractic" the right to exhibit or distribute such representations in whole or in part, without limitations, for any educational purpose that the clinic, and those acting under its authority, deems appropriate.

7) I understand that I may withdraw or revoke my authorization at any time and such revocation must be given to Kids only Chiropractic in writing. If I withdraw my permission, my information may no longer be used for release for the reasons covered by this authorization. However I understand that any disclosure or publication made prior to a revocation may remain in the public domain. I further understand that such authorization will not affect my treatment.

Signature Of Patient / Guardian: _____ Date: _____