Peak Potential
FAMILY CHIROPRACTIC

Pediatric/Adolescent Intake Form

Date: _____

PERSONAL INFORMATION

Child's First Name:_____ M.I.: _____ Last Name: _____

Preferred Name: _____

Address:_____

City / State / Zip: _____

Birth Date: _____ Age:_____ Sex: M F

# of Siblings: _____

Sibling's Names & Ages: _____

Parent's Names: _____

Best Contact Name _____ Phone: ( ) _____

Alternate Contact Name _____ Phone: ( ) _____

Text Reminders: Y N Before Appointment: 1 hr 4 hrs 1 day Cell Provider: _____

Email: _____ *(For updates on office hours, events, etc.)*

Who can we thank for referring you or how did you hear about Peak Potential? _____

_____

REASON FOR SEEKING CARE

What is your reason for seeking care at Peak Potential Family Chiropractic?_____

_____

When did this begin? _____

What is this affecting in your child's life? (check all that apply)

Family Friends School Home Activities

Has your child seen any other providers for this condition? (List all that apply)

_____

Has your child seen a chiropractor before? Yes No

How long ago? _____ Clinic/Doctor Name:_____

What is your reason for the change? (If applicable) _____

Are there any major injuries and/or surgeries we should know about? _____

_____

Goals for Care:

1: _____

2: _____

3: _____

HEALTH CONCERNS

- ☐ Anxiety
- ☐ Depression
- ☐ Irritable
- ☐ Emotional Outbursts
- ☐ Aggression
- ☐ Detachment/Distant
- ☐ Constipation
- ☐ Diarrhea
- ☐ Food Sensitivities/Allergies
- ☐ Picky Eater
- ☐ Nausea
- ☐ Diabetes
- ☐ Bed Wetting
- ☐ Day Wetting
- ☐ Overweight
- ☐ Difficulty Gaining Weight
- ☐ Frequent Sickness
- ☐ Ear Infections
- ☐ Fatigue
- ☐ Sleep Issues
- ☐ Asthma/Chronic Bronchitis
- ☐ Colic/Acid Reflux
- ☐ Nursing Difficulty
- ☐ Back/Neck Pain/Stiffness
- ☐ Headaches
- ☐ Sinus Congestion/ Allergies
- ☐ Eczema
- ☐ Poor motor skills
- ☐ ADD/ADHD
- ☐ Reading Challenges
- ☐ Writing/ Handwriting Challenges
- ☐ Autism/Asperger's
- ☐ Sensory Issues
- ☐ Socialization Challenges
- ☐ Speech Issues
- ☐ Developmental Delay

MEDICATIONS

- ☐ Anxiety/Depression
- ☐ ADD/ADHD
- ☐ Sleep
- ☐ Other _____
- ☐ Headache
- ☐ Digestion
- ☐ Antibiotics

VITAMINS/SUPPLEMENTS

- ☐ Multi-Vitamin
- ☐ Vitamin D3
- ☐ Other _____
- ☐ Fish Oil/Omega-3
- ☐ Probiotics
- ☐ Melatonin

Your Expectations for Chiropractic Care:
(check all that apply)

- ☐ Resolution of a symptom or a problem
- ☐ Resolution & prevention of a symptom
- ☐ Healthier spine & Nervous system
- ☐ Optimal health on all levels
- ☐ Other: _____

PRENATAL HISTORY

Location of birth: ☐Hospital ☐Birthing Center ☐Home Did any of the following happen during delivery:

☐ C-section delivery ☐ Doctor pulled or twisted baby ☐ Anesthesia ☐ Labor was induced

☐ Forceps/vacuum extraction ☐ Premature delivery ☐ Special medical procedures/tests

Rate your stress during pregnancy 1-10: _____ Ultrasound used during pregnancy? Yes No Number of times: _____

During pregnancy, did you experience any illness, complications and/or concerns? If yes, please explain:

_____

Did /do you breastfeed your baby? ☐ Yes ☐ No If yes, how long: _____ Did/do you formula-feed your baby? ☐ Yes ☐ No

At what age did you introduce: Solids:_____ Cow's milk: _____

LIFESTYLE HABITS

Does your child: Exercise daily? ☐ Yes ☐ No Eat balanced meals? ☐ Yes ☐ No Stress at home? ☐ Yes ☐ No

Have a positive self-esteem? ☐ Yes ☐ No Play video games/watch TV for 1+ hours per day? ☐ Yes ☐ No

DEVELOPMENTAL HISTORY

Did/does your child: Struggle with nursing/latching? ☐ Yes ☐ No Struggle with tummy time? ☐ Yes ☐ No

Roll to both sides? ☐ Yes ☐ No Cross Crawl? ☐ Yes ☐ No Scoot/Bear/Army crawl? ☐ Yes ☐ No

Walk by 18 months? ☐ Yes ☐ No Talk by 2 years? ☐ Yes ☐ No Struggle with potty training? ☐ Yes ☐ No

Have attachment issues? ☐ Yes ☐ No Have difficulty with peers? ☐ Yes ☐ No

PERMISSION TO TREAT A MINOR

I, (Parent/Guardian) _____, give Peak Potential Family Chiropractic permission to examine and adjust _____.

Minor date of birth: _____

Parent/Guardian Signature: _____ Date: _____

PATIENT HIPAA CONSENT FORM

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to define situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment, or practice operations will be made only after obtaining your consent. You may request restrictions on your disclosures. You may inspect and receive copies of your records within 30 days with a request. You may request to view charges to your records. In the future, we may contact you for appointment reminders, announcments, and to inform you about our practice and its staff.

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to: conduct, plan, and direct my treatment and follow up with multiple healthcare providers who may be involved in that treatment directly or indirectly, obtain payment from third party payers, and conduct normal healthcare operations such as quality assessments and physician's certificates. I have read and understand your Notice of Privacy Practices. I also understand that I can request in writing that you restrict how my personal information is used and disclosed.

Date: _____ Print Patient Name: _____

Signature:_____ Relationship to Patient:_____

FINANCIAL POLICY

Our goal is to provide the highest quality of healthcare possible for our patients. In order to achieve this goal, we need your commitment as well.

- We urge our patients to follow the doctors' recommendations for care. Please keep your appointments as scheduled or call our office within 24 hours to make any changes. In order to attain the level of achievement we both desire, care must be followed.
- I authorize Peak Potential Family Chiropractic to release any information deemed appropriate concerning my physical condition to any insurance company, attorney, or adjuster in order to process any claim for reimbursement charges incurred by me.
- Chiropractic care in this office deals with vertebral subluxation, and will therefore be billed under the S8990 adjustment code. While we will provide an itemized receipt upon your request, we anticipate that care will not be reimbursed by a third party carrier. This does not apply to PI, WSI, or Medicare. HSA and FLEX spending accounts may be utilized.
- I authorize the direct payment to Peak Potential Family Chiripractic of any sum I now or hereafter owe by my attorney out of settlement of my case and by any insurance company obligated to make payment to me or Peak Potential Family Chiropractic based in whole or in part upon the charges made for services received. I hereby appoint Peak Potential Family Chiropractic authority to endorse and cash checks, drafts, or money orders made payable to the undersigned or as co-payee with this clinic or payments due for services rendered on behalf of the undersigned by Peak Potential Family Chiropractic.
- If you have any questions about our financial policies, please ask our staff. If you need to make special arrangements, please ask. We will do everything possible to meet your financial needs.
- *Advanced Beneficiary Notice of NON-Coverage (ABN)*. Your health insurance does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect your health insurance will not pay for items and services such as your initial visit and any chiropractic care deemed maintenance or wellness care by your carrier (as well as other items that may arise in the future). Signing below signifies that you want these items and services, but understand that they will not be billed to your insurance company. Therefore, you are responsible for payment and cannot appeal to your insurance carrier as they were not submitted and/or billed to them. This notice gives our opinion, not an official Medicare or other insurance carrier's decision. If you have other questions, please ask our staff. Signing below means that you have received and understand this notice.

Date: _____ Parent/Guardian Signature : _____

AUTHORIZATION FOR CARE

I hereby authorize the doctors and staff at Peak Potential to treat my child's condition as deemed appropriate. At Peak Potential Family Chiropractic we do not diagnose or treat any disease or condition other than vertebral subluxation and the doctors/clinic will not be held responsible for any pre-existing medical conditions. I certify that the above information is correct to the best of my knowledge. I will not hold the doctors or any staff member of Peak Potential Family Chiropractic responsible for any errors or omissions that I may have made in the completion this form. Chiropractic, as well as all other types of health care is associated with potential risks in the delivery of treatment. While chiropractic treatment is remarkably safe, you need to be informed about the potential risks related to your child's care to allow you to be fully informed before consenting to treatment. Please inquire if you have further questions. Chiropractic is a system of health care delivery and therefore, as with any health care delivery system, we cannot promise a cure for any symptom, condition, or disease as a result of treatment in this office. An attempt to provide you with the very best care is our goal, and if the results are not acceptable, we will refer you to another provider who we feel can further assist you.

Date: _____ Parent/Guardian Signature : _____