Pediatric Intake Form

PATIENT INFORMATION:

Date: _____

First name: _____ Middle initial: _____ Last name: _____

Date of Birth: _____ Age: _____ Gender: _____

Address: _____

(Street) (City, State) (Postal Code)

Parent/Guardian: _____ Email address: _____

Preferred phone number: _____ Has your child ever been to a Chiropractor? Yes

If Yes, please provide the name of the office & doctor _____

Were x-rays taken? Yes

Name of Pediatrician: _____ Permission to contact for labs, etc. Yes

How did you hear about this office? ☐ Sign ☐ Website ☐ Facebook ☐ Newspaper

☐ Referral: _____ ☐ Other: _____

PRENATAL HISTORY:

Is your child adopted? Yes

Mother's age at child's birth: _____

Please describe any complications during pregnancy: _____

Was the child exposed to cigarette smoke during pregnancy? Yes

Has the child been exposed to cigarette smoke on a regular basis? Yes

Were there any medications taken during the pregnancy? Yes

If so, what medications? _____

How many ultrasounds were performed during the pregnancy? _____

BIRTH HISTORY:

Place of birth: ☐ Home ☐ Birthing Center ☐ Hospital

Provider: ☐ Midwife ☐ OB-Gyn ☐ Other: _____

Type of birth: ☐ Vaginal ☐ Scheduled C-Section ☐ Emergency C-Section ☐ C-Section ☐ VBAC

Were pain medications used? Yes If so, what type: _____

Was labor induced? Yes

How long was the labor? _____

What position was mother in at delivery? ☐ Squatting ☐ On back ☐ Other

Birth trauma? ☐ Doctor assisted ☐ Twisting/ pulling ☐ Vacuum Extraction ☐ Forceps

Was/ is the child breastfed? Yes

Did/Does the child prefer one breast over the other? Yes If so, which side? Neither

Please list any food allergies:_____

Were immunizations administered? Yes If yes, which vaccines? _____

Were there any negative reactions to the vaccines? Yes

Please list any surgeries as well as month and year of surgeries:

_____

Has the patient taken antiobiotics? Yes

Please list any medications:_____

Please list any vitamins:_____

BABY/ TODDLER (0-4)

Please check if any of the following have occurred:

- ☐ Fall
- ☐ Crying more than 3 hours a day
- ☐ Tumble down stairs
- ☐ In a car crash
- ☐ Fall out of crib
- ☐ Fall off playground
- ☐ Play in a Johnny Jumper
- ☐ Frequent ear infections
- ☐ Tonsillitis
- ☐ Frequent fevers
- ☐ Frequent diarrhea
- ☐ Frequent constipation
- ☐ Sleeping problems
- ☐ Repeated infections or colds
- ☐ Colic
- ☐ Other: _____
- ☐ Allergies: _____

CHILD (5-12)

Have any of the following occurred?

- ☐ Fall from a tree/ bike, etc.
- ☐ Sports accident
- ☐ In a car crash
- ☐ Asthma
- ☐ Stomach pains
- ☐ Scoliosis
- ☐ Bed wetting
- ☐ Headaches
- ☐ Hyperactivity
- ☐ Learning difficulties
- ☐ Growing pains
- ☐ Autism
- ☐ Allergies: _____
- ☐ Other: _____

WHAT BRINGS YOU INTO THE CHIROPRACTIC OFFICE TODAY?

☐ Wellness check ☐ Scoliosis screen

☐ Injury: _____

☐ Pain: _____

☐ Concern: _____

When did it begin?_____

Is it getting worse? Yes

Does the complaint affect child's activity? Not at all Somewhat Always Always

How would you rate the child's diet? Well-balanced Average High sugar/ processed foods Well-balance

Sleep quality: Good Fair Poor Good

FAMILY & PERSONAL HISTORY

Please list family members (or yourself) who have the following conditions:

Cancer:	Autoimmune disease:
Diabetes:	Arthritis:
High blood pressure:	Allergies:
Stroke:	Asthma:
Thyroid disease:	Mental Illness:

INFORMED CONSENT

I understand that I am primarily responsible for my health care, and that I am seeking advice, treatment, and knowledge about my health and current health condition(s). I understand that I may or may not choose to follow the Doctor's advice and/or recommendations and that my failure to do so may effect the potential outcome of my treatment. I understand that it is my responsibility to ask questions about my treatment and/or condition if I do not fully understand what has been said and/or presented to me. I understand that any type of care I receive, including Chiropractic care, has a certain level of risk including, but not limited to the possibility of stroke, fracture and/or death, and that it is ultimately my decision whether or not to receive this or any other care.

I understand that I am financially responsible for all charges.

I authorize Ashley Seaver, D.C. to treat my condition, and any future conditions when I am in her office.

_____ _____ _____

Printed Name Signature Date

_____ _____ _____

Guardian Signature Date

HIPAA

Ashley L. Seaver, D.C. (the "Provider") Effective Date: July 1, 2016

1. Patient Consent to Treat
   I, the undersigned patient, consent to such treatment procedures as are deemed necessary by the Provider, including those which are in additional to or different from those initially contemplated, and which are deemed necessary or advisable by the Provider in the course of treatment.

2. Patient Consent for Use and Disclosure of Protected Health Information ("PHI")
   I, the undersigned patient, give my consent to the Provider entity and its agent to use or disclose my protected health information ("PHI") to carry out treatment, payment, or health care operations. These individuals and entities can release, use, or disclose my PHI to other health care personnel including, but not limited to physicians, physicians assistants, child life specialists, physical therapists, respiratory therapists, X-ray personnel, audiologists, students in each of the above disciplines, and other such entities or persons as are deemed related to treatment, payment, and health care operations, as determined in the sole discretion of the Provider, his/her practice group, and their respective agents.

3. Permission to Release Medical Records to Providers
   If another provider who is involved with treatment, payment, or health care operations relating to me requests my medical records, I consent to the release of my entire medical record maintained by the Provider to those other providers.

4. Permission to Release Billing Information Over the Telephone
   I agree, as part of this consent for payment operations, that the Provider, its group and their billing personnel, billing agents, or management company can disclose billing information to any person that calls the Provider with billing questions after the provider inquires as to the identity of the calling person and the calling person provides my correct social security number or health plan number.

5. Permission to Call and Leave Voice Mail Messages
   I agree that the Provider or its agents or representatives may call and leave a voice mail message at my home or other number I provide them regarding medical appointments, billing or payment issues, or other information related to treatment, payment, or health care operations.

6. Permission to E-Mail
   I grant permission to the Provider to e-mail to my home or other alternative location, any items that assist the practice in carrying out TPO. My e-mail address is the following:

   _____

7. Permission to Discuss Protected Health Information with Third Persons
   I agree that the Provider may discuss my PHI with any person that accompanies me to a visit or procedure or is present with me when the Provider is present. The Provider may rightly assume if another person is with me, I have no objection to disclosure of my PHI to that person. I also agree that the Provider may discuss my PHI with any person that identifies him r herself as active in my mental, physical, emotional, or spiritual care, including but not limited to family, friends, clergy, and patient advocates. Ii also agree that the Provider, his/her practice group, and their agents may disclose my PHI to employers who arrange and pay, directly or indirectly, for my medical treatment.

8. Permission to Discuss Protected Health Information Regarding Minors
   I agree that the Provider, his/her practice group, and their agents may discuss my child's PHI with the person accompanying the child. I agree that the Provider may discuss PHI with both natural parents and stepparents. I acknowledge that state law may grant my child certain privacy rights regarding the child's PHI, and that I have no right to receive this information.

9. Permission to Discuss Protected Health Information with Public Agencies
   I agree the Provider, his/her practice group, and their agents may, upon request by the following entities, disclose my PHI to public health agencies, law enforcement, and the FDA.

10. Acknowledgment of Receipt of Notice of Privacy Practices
    I acknowledge that I have received from this Provider a copy of a separate document, entitles, "Notice of Privacy Practices" which sets forth this provider's privacy practices and my rights regarding privacy of my PHI. The terms of the "Notice of Privacy Practices" may change. If the Provider changes its "Notice of Privacy Practices", I understand I may obtain a revised copy by contacting the Provider's office. A copy of this "Notice of Privacy Practices" is located in the waiting room and is available to me at any time. I understand that I have the right to review the "Notice of Privacy Practices" prior to signing this consent.

11. Right to Restrict Protected Health Information; Right to Revoke Consent
    I understand that I have the right to request that the Provider restrict how my PHI is used or disclosed for treatment, payment or health care operations, and that the Provider is not required to agree to this restriction. If the Provider does agree to the restriction, however, the Provider is bound by such agreement. I also understand that I have the right to revoke this consent, in writing, except where the Provider has already made disclosures in reliance on my prior consent.

12. **I understand that Dr. Ashley Seaver DOES NOT accept insurances or third party payments of any kind including, but not limited to Medicare. I further understand that I am receiving wellness care which is not covered by any third party payer or insurance including Medicare, and I wave my right to file reimbursement from any third party payer or insurance company in relation to any treatment received from Dr. Ashley Seaver in the future. Upon request I will be provided with a receipt only for proof of payment for services.**

_____ _____

Patient Signature of Personal Representative Date

_____

Relationship, if Personal Representative