VERTICAL® CHIROPRACTIC

PEDIATRIC INTAKE FORM

PATIENT INFORMATION

Patient Name _____
Address _____
City _____ State _____ Zip _____
Home Phone _____
Cell Phone _____
Email _____
Sex M F Age ____ Birthday _____

IN CASE OF EMERGENCY, CONTACT

Name _____
Relationship _____
Contact Number _____

Mother's Name _____
Mother's Occupation _____
Mother's Phone _____
Mother's Email _____

Father's Name _____
Father's Occupation _____
Father's Phone _____
Father's Email _____

Who may we thank for referring you?

_____

HOW CAN WE HELP YOUR CHILD?

❑ Wellness Checkup ❑ Other: _____

If your child is already experiencing a symptom, please describe it:

_____

_____

_____

_____

Has your child been treated on an emergency basis? ❑ Yes ❑ No

Please describe: _____

PREGNANCY HISTORY

Did you experience any complications during your pregnancy? (check all that apply)

❑ Back/Other Pain ❑ Gestational Diabetes ❑ Pre/Eclampsia ❑ Strep B ❑ Nausea/Vomiting
❑ Pre-Term ❑ Fatigue ❑ Swelling ❑ Other (please describe) _____

_____

BIRTH HISTORY

Type of birth (check all that apply):

❑ Hospital ❑ Birth Center ❑ Home ❑ Normal / Vaginal ❑ Breech
❑ Cesarean ❑ Scheduled/Induced ❑ Epidural

Problems during labor / delivery? _____

_____

❑ Antibiotics ❑ Congenital Anomalies ❑ Failure to Thrive ❑ Jaundice ❑ Meconium
❑ Respiratory Distress ❑ Extended Hospitalization ❑ Other _____

GROWTH & DEVELOPMENT

Infant feeding: ❑ Breast ❑ Bottle ❑ Formula

Number of hours of sleep each night:_____ Quality of sleep: _____

At what age did the child:

Respond to sound: _____ Crawl: _____ Hold head up: _____

Stand: _____ Sit unsupported: _____ Walk unsupported: _____

CHILDHOOD DISEASE, ILLNESS & VACCINATIONS

Has your child had (check all that apply)?:

❑ Chicken Pox ❑ Measles ❑ Robiola

❑ Mumps ❑ Rubella ❑ Pertussis/Whooping Cough

Has your child ever suffered from (check all that apply)?:

❑ Allergies ❑ Broken Bones ❑ Digestive Issues (constipation/diarrhea) ❑ Hypertension ❑ Orthopedic Problems

❑ Anemia ❑ Chronic Ear Aches ❑ Juvenile / Rheumatoid Arthritis ❑ Paralysis

❑ Arm Problems ❑ Colds/Flu ❑ Dizziness ❑ Poor Appetite

❑ Asthma ❑ Colic ❑ Fainting ❑ Joint Problems ❑ Ruptures/Hernias

❑ Back Aches ❑ Convulsions/Seizures ❑ Headaches ❑ Leg Problems ❑ Sinus Trouble

❑ Bed Wetting ❑ Delayed Speech ❑ Heart Trouble ❑ Neck Problems ❑ Tuberculosis

❑ Behavioral Problems ❑ Diabetes ❑ Hyperactivity ❑ Neuritis ❑ Walking Problems

Have you vaccinated your child?

❑ No ❑ Yes ❑ As Scheduled ❑ Delayed Schedule ❑ COVID Vaccine

ALLERGIES, MEDICATIONS, SURGERGIES, & FAMILY HISTORY

ALLERGIES (list)

_____

_____

MEDICATIONS (list)

_____

_____

SURGERIES (list)

_____

_____

FAMILY HISTORY (list)

_____

_____

SIBLINGS

How many children do you have?_____ Number of pregnancies: _____

Children's Ages:_____ Are you currently pregnant? ❑ No ❑ Yes, I'm due: _____

Children's health concerns:_____ Health concerns regarding this pregnancy? _____

_____ _____

Authorization for Care of Minor

I hereby authorize this clinic and its doctor(s) to administer care as they so deem necessary to my son/daughter/ward.

Parent/Guardian Signature: _____ Witnessed: _____ Date: _____

According to the National Safety Council, approximately 50% of children fall head first from a high place during their first year of life (i.e. a bed, changing table, down stairs).

Did you child have a fall similar to what was described above? □ Yes □ No

Explain: _____

Has your child been involved in any sports? □ Yes □ No List: _____

Please list all past broken bones, surgeries or hospitalizations: _____

_____

Other traumas not listed: _____

Is there anything else you would like us to know about your child?

_____

FAMILY HISTORY:

Does anyone in your family been diagnoses with: □ Heart Disease □ High Blood Pressure □ Kidney Disease □ Lung Disease □ Diabetes □ High Cholesterol □ Asthma □ Cancer □ Stroke □ Alzheimer's/dementia □ Osteoporosis □ Genetic Disorder

Please list child, spouse, sibling, mother, and/or father and diagnosis: _____

_____

EXPERIENCE WITH CHIROPRACTIC:

Have your child seen a Chiropractor before? □ Yes □ No Reason for visits: _____

Favorable outcomes? □ Yes □ No Explain: _____

Are you aware of any poor posture habits of your child/children? □ Yes □ No Explain: _____

Do you have other children that have not had their spines checked? □ Yes □ No

ACKNOWLEGMENTS: Please read each statement and initial your agreement on the left.

_____ **Insurance Information**
I clearly understand that all insurance coverage is an arrangement between my insurance carrier and me. If this office chooses to bill any services to my insurance carrier that they are performing these services strictly as a convenience for me. This office will provide any necessary report or required information to aid in insurance reimbursement of services, but I understand that insurance carriers may deny any claim and that I am ultimately held responsible for any unpaid balances. Any monies received will be credited to my account.

_____ **Privacy Policy**
I understand and have been provided with the opportunity to review a Notice of Privacy Practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or health care operations.

_____ **Appointment Reminders and Health Care Information Authorization**
Your chiropractor and members of the practice staff may need to use your name, address, phone number, and your clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If this contact is made by phone and you are not at home, a message will be left on your answering machine. By signing this form, you are giving us authorization to contact you with these reminders and information.

By signing below, you are acknowledging that to the best of your ability, the information you have supplied is complete and truthful. You have not misrepresented the presence, severity, or cause of your health concern.

_____ _____

Parent / Guardian Signature Date Doctor Signature Date

This information is confidential. If we do not sincerely believe your problem will respond favorably, we will not be able to accept your case. We will refer you to a health professional we believe will help you. In order for us to understand your health problems properly, please make sure you completed this form neatly, accurately, and completely.