MISSION
-CHIROPRACTIC & WELLNESS-

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PEDIATRIC INTAKE
Infants – School Aged Children

PATIENT INFORMATION

Child's Name:_____ Parent/Guardian Name:_____

Gender: ☐Male ☐Female D.O.B:_____/_____/_____ Age_____ Current Height:_____ Current Weight:_____

Address: _____City, State, Zip: _____

Other Children's names/ages: _____

Email: _____ Home Phone: _____

Cell Phone: _____ Cell Provider:_____ ☐Yes! I want to opt for text appt reminders

How did you hear about us? _____ Has your child been adjusted by a chiropractor before? ☐YES ☐NO

If yes, reason for those visits: _____ When was the last visit?_____

Is your child receiving care from other health professionals? ☐YES ☐NO If yes, list name and specialty: _____

Who is your families primary care physician?_____ Contact information:_____

HEALTH HISTORY

Describe the health concern that prompted this visit:_____

When did this concern begin? _____ How did this concern begin? _____

Has this condition: ☐Worsened ☐Stayed the same ☐Been Intermittent Does this interfere with: ☐School ☐Sleep ☐Daily Routine

What makes this condition worse? _____ What makes this condition better? _____

Has your child seen anyone else for this concern? ☐YES ☐NO Type of treatment:_____

Please list any medications taken for this concern:_____

Child's birth was at: ☐Home ☐Birthing Center ☐Hospital OB/Midwife/Physician was:_____

Child birth was: ☐**Natural vaginal with no medications**

☐**Vaginal with interventions**: ☐Pitocin ☐ Epidural ☐Pain Medications ☐Vacuum Extraction ☐Forceps
☐IV antibiotics ☐Other:_____

☐**C-Section:** ☐Scheduled ☐Emergency

☐Adopted ☐Prenatal history unknown ☐Birth history unknown

Was your child at anytime during your pregnancy in a constrained position?: ☐ YES ☐NO ☐ UNSURE

If yes, please describe: ☐Breech ☐Transverse ☐Face/Brow presentation

Complications during pregnancy: ☐ YES ☐NO (If yes, describe)_____

Medications during pregnancy: : ☐YES ☐NO (If yes, describe)_____

If so, which ones and how often? (include OTC):_____

Exposure to drugs, alcohol, cigarettes, or second hand smoke during pregnancy: : ☐YES ☐NO (If yes, describe)_____

_____

Birth Weight:_____lbs _____oz Birth Height:_____

Please list all hospitalizations and surgical history (include year):_____

_____

Please list any major injuries, accidents, falls and/or fractures you child has sustained in his/her lifetime: _____

_____

The human body is designed to be healthy. The primary system in the body, which coordinates health and function, is the nervous system. Your nervous system is surrounded and protected by the bones of the spine, called vertebrae. Many of the common health challenges that adults experience have their origins during the developmental years, starting at birth. Layers of damage to the spine and nervous system occur as a result of various traumas, toxins, and emotional stress. The result may be misalignment to the spinal column and damage to the nervous system – a condition called Vertebral Subluxation. Please answer the following questions to give us a better understanding about your child's state of wellness and factors which may be contributing to vertebral subluxation and *impeding your child's ability to heal.*

What signals has your child's body been communicating?

CURRENT	PREVIOUS		CURRENT	PREVIOUS		CURRENT	PREVIOUS	
☐	☐	Asthma	☐	☐	Frequent Diarrhea	☐	☐	Failure to Thrive / Slow Weight Gain
☐	☐	Respiratory Tract Infections	☐	☐	Constipation	☐	☐	Slow or Absent Refluxes
☐	☐	Sinus Problems	☐	☐	Flatulence	☐	☐	Asymmetrical Crawling or Gait
☐	☐	Ear Infections	☐	☐	Headaches/Migraines	☐	☐	Weight Challenges
☐	☐	Tonsillitis	☐	☐	Neck Pain	☐	☐	Bed Wetting
☐	☐	Strep Throat	☐	☐	Torticollis/Head Tilt	☐	☐	Sleeping Problems
☐	☐	Frequent Colds/Croup	☐	☐	Trouble Nursing	☐	☐	Night Terrors
☐	☐	Recurrent Fevers	☐	☐	Back Pain	☐	☐	Tip Toe Walking
☐	☐	Eczema	☐	☐	Growing Pains	☐	☐	Sensory Processing Issues
☐	☐	Rashes	☐	☐	Scoliosis	☐	☐	Seizures
☐	☐	Allergies	☐	☐	Red, Swollen, Painful Joints	☐	☐	Tremors / Shaking
☐	☐	Food Sensitivities	☐	☐	Colic	☐	☐	ADD / ADHD
☐	☐	Digestive Problems	☐	☐	Frequent Crying Spells	☐	☐	Autism

Other:_____

What is your primary goal for your child at our clinic? _____

Our goal is to provide a detailed assessment of your child's current health status and provide you with the resources for a highly engaged and healthy child whose body is functioning at its absolute peak potential while they grow. Essential to this healthy growth is a properly functioning nervous system that is able to function free from interference called subluxation.

Dr. Dan Reed is certified in both pregnancy and pediatrics, is certified in the Webster Technique and is a member of the International Chiropractic Pediatric Association.

Terms of Acceptance

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective. Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

ADJUSTMENT: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxations. Our chiropractic method of correction is by specific adjustments to the spine.

HEALTH: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

VERTEBRAL SUBLUXATION: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxations. However, if during the course of chiropractic spinal examination, we encounter non-chiropractic or unusual finding, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of another health care provider.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, _____ have read and fully understand the above statements.

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

Signature_____ Date_____

Notice of Privacy Practices Acknowledgement

I understand that I have certain rights of privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

1. Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations, such as quality assessments and physician's certifications.

I acknowledge that I may request your NOTICE OF PRIVACY PRACTICES containing a more complete description of the uses and disclosures of my health information. I also understand that I may request, in writing, that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operation. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

Signature_____ Date_____

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Informed Consent

REGARDING: Chiropractic Adjustments, Modalities, and Therapeutic Procedures:

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risk are most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments.

Treatment objectives as well as the risks associated with chiropractic adjustments and, all other procedures provided at Mission Chiropractic and Wellness have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

_____ ____/____/____ ☐ *Witness Initials*

Patient or Authorized Person's Signature Date

REGARDING: X-rays/Imaging Studies

FEMALES ONLY → *please read carefully and check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our receptionist for further explanation.*

☐ The first day of my last menstrual cycle was on ____-____-____ (Date)

☐ I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I am not pregnant.

By my signature below I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

_____ ____/____/____ ☐ *Witness Initials*

Patient or Authorized Person's Signature Date

WRITTEN CONSENT FOR A CHILD

Name of practice member who is a minor / child: _____

I authorize Dr. Dan Reed and any and all Mission Chiropractic and Wellness staff to perform diagnostic procedures, radiographic evaluations, chiropractic adjustments, and to render chiropractic care to my minor / child.

As of this date, I have the legal right to select and authorize health care services for my minor / child. If my authority to select and authorize care is revoked or altered, I will immediately notify Clear Health Chiropractic.

_____ _____

DATE ***GUARDIAN SIGNATURE***

_____ _____

WITNESS SIGNATURE ***GUARDIAN'S RELATIONSHIP TO MINOR / CHILD***