LIFTED CHIROPRACTIC

PEDIATRIC INTAKE FORM

PERSONAL INFORMATION

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

Preferred Name: _____ Social Security Number: _____

Address:_____

City / State / Zip: _____

Cell Phone: ( ) _____ Alternate Phone: ( ) _____

Text Reminders: Y N Before Appointment: 1 hr 4 hrs

Email: _____ *(for updates on office hours, events, ect.)*

Birth Date: _____ Age:____

#of Siblings_____Sibling's Names_____

Parent's Names:_____

Best Contact: _____

Alternate Contact_____

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

_____

REASON FOR SEEKING CARE

What is your reason for seeking care at LIFTED Chiropractic? _____

_____

When did this begin? (If applicable)_____

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

_____

What is this affecting that is MOST important in your child's life? (List all that apply) _____

_____

Have you seen any other providers for this condition? (List all that apply)_____

_____

Have you seen a chiropractor before? **Yes No**

How long ago? _____ Clinic/Doctor Name: _____

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

What is your level of commitment to yourself and your health? 1 2 3 4 5 6 7 8 9 10

Explain: _____

What health goal, if you were to complete or accomplish it, would have the greatest impact on your child's life?_____

_____

HEALTH CONCERNS

☐Anxiety/Depression
☐ Fatigue/Sleep Issues
☐ Digestive Troubles
☐ Bed Wetting
☐ Nausea/Vomiting
☐ Overweight
☐ Diabetes
☐ Frequent Sickness
☐ ADD/ADHD
☐ Loss of Concentration
☐ Developmental Delay
☐Detachemnt/Distant
☐Irritability/Nervous
☐ Asthma/Chronic Bronchitis
☐ Colic/Acid Reflux
☐ Headaches
☐ Neck/Back Pain
☐ Difficulty Gaining Weight
☐ Ear or Other Infections
☐ Sinus Troubles/Allergies
☐ Learning Disorders
☐Autism/Asperger's/Sensory Issues
☐Other_____
_____
_____

Explain any boxes checked above or add additional concerns:

_____
_____
_____
_____
_____

Is there anything else regarding your child's current condition you feel the doctor should know?_____

_____
_____

MEDICATIONS/SUPPLEMENTS

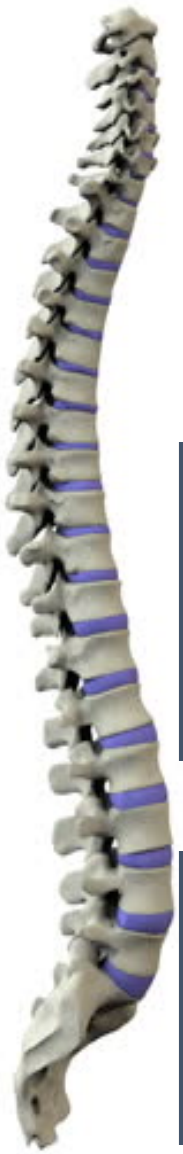
☐ Anxiety/Depression
☐ Migraine/Headache
☐ Blood Pressure
☐ Cholesterol
☐ Pain Narcotics
☐ ADD/ADHD
☐ Diabetes
☐ Muscle Relaxers
☐ Other_____
☐ Supplements_____
☐ Supplements_____

Explain any boxes checked above_____

_____
_____
_____

Did You Know...

Each health concern relates to a specific area of the spine and nervous system? Please circle below or enter the information to the left.



Headaches Migraines
Dizziness
Sinus Problems
Allergies Fatigue
Sleep Problems Head
Colds
Vision Problems
Difficulty
Concentrating
Hearing Problems
Asthma
Allergies
High Blood Pressure
Neck Pain
Arm Pain

Middle Back Pain
Congestion
Difficulty Breathing
Bronchitis
Pneumonia
Gallbladder
Conditions Stomach
Problems Ulcers
Gastritis
Kidney Problems
Indigestion

Constipation
Colitis
Diarrhea
Gas Pain
Irritable Bowel
Bladder Problems
Low Back Pain
Pain in legs
Reproductive
Problems

EMERGENCY CONTACT

First Name: _____ M.I.: _____ Last Name: _____
Address:_____
City / State / Zip: _____
Phone: ( ) _____ Relation: _____

PRENATAL HISTORY

Location of birth: **Home** **Birthing Center** **Hospital** Other: _____
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
Describe any of the above plus any additional complications experienced during delivery:

_____

_____ _____

During pregnancy, did you experience any illness, complications and/or concerns? If yes, please explain:_____
Birth weight: _____ Birth length: _____ APGAR scores: _____
Ultrasound used during pregnancy? Yes No Number of times: _____
Did /do you breastfeed the baby? Yes No If yes, how long: _____
Did/do you formula-feed the baby? Yes No If yes, how long: _____
At what age did you introduce: Solids:_____ Cow's milk: _____

LIFESTYLE HABITS

Does your child..... Exercise daily? Yes No How much? _____
Have a positive self-esteem or self-image? Yes No
Play video games or watch TV for more than one hour per day? Yes No How much? _____
Eat balanced meals? Yes No
Experience prolonged sadness? Yes No Explain:_____
Have difficulty sleeping? Yes No Explain: _____

CURRENT HEALTH STATUS

Has your child ever been hospitalized or had surgery? Yes No Explain:_____
Does your child have difficulty interacting with others? Yes No Explain:_____
Have you noticed that your child is nervous, twitches, shakes, or exhibits rocking behavior? Yes No Explain: _____
Has your child been involved in any high impact/contact sports (soccer, football, martial arts, cheerleading, etc.)? Yes No Please list: _____
Are you aware of any food allergies or intolerance? Yes No Explain: _____
Has your child received all recommended vaccinations? Yes No Explain: _____
Please rate stress levels on a scale of 1-10 (10 being highest)
School: 1 2 3 4 5 6 7 8 9 10 Personal: 1 2 3 4 5 6 7 8 9 10

PERMISSION TO TREAT MINOR

I, (Parent/Guardian) _____, give Lifted Chiropractic permission to examine, x-ray (if necessary), and treat _____
Minor date of birth: _____
Parent/Guardian Signature: _____ Date: _____
Witness Signature: _____Date:_____

X-RAY AUTHORIZATION FORM

X-RAY AUTHORIZATION AS YOUR HEALTHCARE PROVIDER, WE ARE LEGALLY RESPONISBLE FOR YOUR CHIROPRACTIC RECORDS. WE MUST MAINTAIN A RECORD OF YOUR X-RAYS IN OUR FILES. AT YOUR REQUEST, WE WILL PROVIDE YOU WITH A COPY OF YOUR X-RAYS IN OUR FILES. **THE FEE FOR COPYING YOUR X-RAYS ON A DISC IS $15.00. THIS FEE MUST BE PAID IN ADVANCE.**

DIGITAL X-RAYS ON CD WILL BE AVAILABLE WITHIN 72 HOURS OF PREPAYMENT DURING REGULAR OPERATING HOURS. PLEASE NOTE: X-RAYS ARE UTILIZED IN THIS OFFICE TO HELP LOCATE AND ANALYZE VERTEBRAL SUBLUXATIONS. THESE X-RAYS ARE NOT USED TO INVESTIGATE FOR MEDICAL PATHOLOGY. THE DOCTORS OF LIFTED CHIROPRACTIC DO NOT DIAGNOSE OR TREAT MEDICAL CONDITIONS. HOWEVER, IF ANY ABNORMALITIES ARE FOUND, THEY WILL BE BROUGHT TO YOUR ATTENTION SO THAT YOU CAN SEEK PROPER MEDICAL ADVICE. BY SIGNING BELOW, YOU ARE AGREEING TO THE ABOVE TERMS AND CONDITIONS.

PRINT NAME_____**DATE**_____

SIGNATURE_____**AGE**_____

FEMALE PATIENTS ONLY: TO THE BEST OF MY KNOWLEDGE, I BELIEVE I AM NOT PREGNANT AT THE TIME X-RAYS ARE TAKEN AT LIFTED CHIROPRACTIC.

SIGNATURE_____ **DATE**_____

FOR OFFICE USE ONLY

ID #_____ V_____

DOB_____ P_____

ROF_____ A_____

OTHER_____ M___/___ ___/___ ___/___ __/___

Terms of Acceptance

To provide for the most effective healing environment, most effective application of chiropractic procedures, and the strongest possible doctor-patient relationship, it is our wish to provide each patient with a set of parameters and declarations that will facilitate the goal of optimum health through chiropractic.
To that end, we ask that you acknowledge the following points regarding chiropractic care and the services that are offered through this clinic:

A. Chiropractic is a very specific science, authorized by law to address spinal health concerns and needs. Chiropractic is a separate and distinct science, art and practice. It is not the practice of medicine.
B. Chiropractic seeks to maximize the inherent healing power of the human body by restoring normal nerve functions through the adjustment of spinal subluxation(s). Subluxations are deviations from normal spinal structures and configurations that interfere with normal nerve processes.
C. The chiropractic adjustment process, as defined in the law of this jurisdiction, involves the application of a specific directional thrust to a region or regions of the spine with the specific intent of re-positioning misaligned spinal segments. This is a safe, effective procedure applied over one million times each day by doctors of chiropractic in the united states alone.
D. A thorough chiropractic examination and evaluation is part of the standard chiropractic procedure. The goal of this process is to identify any spinal health problems and chiropractic needs. If during this process, any condition or question outside the scope of chiropractic is identified, you will receive a prompt referral to an appropriate provider or specialist, per the initial indications of the need.
E. Chiropractic does not seek to replace or compete with your medical, dental, or other type(s) of health professionals. They retain responsibility for care and management of medical conditions. We do not offer advice regarding treatment prescribed by others.
F. Your compliance with care plans, home and self-care etc., is essential to maximum and optimal health through chiropractic.
G. We invite you to speak frankly to the doctor on any matter related to your care at this facility, its nature, duration or cost, in what we work to maintain as a supporting open environment.

By my signature below, I have read and fully understand the above statements.
All questions regarding the doctor's objective pertaining to my care in this office have been answered to my 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 and Accountability Act of 1996 (HIPPA). 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 physicians certifications.

I acknowledge that I may request your NOTICE OF PRIVCACY PRACTICE 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 to carry out treatment, payment, or healthcare operation. I also understand you are not required to agree to my requested restrictions, but if you agree, then you are bound to abide by such.

Signature_____ Date_____

Informed Concent

FOR CHIROPRACTIC CARE CHIROPRACTIC CARE, LIKE ALL FORMS OF HEALTHCARE WHILE OFFERING CONSIDERABLE BENEFITS MAY ALSO PROVIDE SOME LEVEL OF RISK. THIS LEVEL OF RISK IS MOST OFTEN VERY MINIMAL, YET IN RARE CASES, INJURY HAS BEEN ASSOCIATED WITH CHIROPRACTIC CARE. THE TYPES OF COMPLICATIONS THAT HAVE BEEN REPORTED SECONDARY TO CHIROPRACTIC CARE INCLUDES: SPRAIN/STRAIN INJURIES, IRRITATION OF A DISC CONDITION, AND RARELY, FRACTURES. ONE OF THE RAREST COMPLICATIONS ASSOCIATED WITH CHIROPRACTIC CARE OCCURRING AT A RATE BETWEEN ONE INSTANCE PER ONE MILLION TO ONE PER TWO MILLION CERVICAL SPINE (NECK) ADJUSTMENTS MAY BE A VERTEBRAL INJURY THAT COULD LEAD TO A STROKE.

PRIOR TO RECEIVING CHIROPRACTIC CARE IN THIS CHIROPRACTIC OFFICE, A HEALTH HISTORY AND PHYSCIAL EXAMINATION WILL BE COMPLETED. THESE PROCEDURES ARE PERFORMED TO ASSESS YOUR SPECIFIC CONDITIONS, YOUR OVERALL HEALTH AND YOUR SPNAL HEALTH. THESE PROCEDURES WILL ASSIST US IN DETERMINING IF CHIROPRACTIC CARE IS NEEDED, OR IF ANY FURTHER EXAMINATIONS OR STUDIES ARE NEEDED. IN ADDITION, THEY WILL HELP US DETERMINE IF THERE IS ANY REASON TO MODIFY YOUR CARE OR PROVIDE YOU WITH A REFERRAL TO ANOTHER HEALTH CARE PROVIDER. ALL RELEVANT FINDINGS WILL BE REPORTED TO YOU ALONG WITH A CARE PLAN PRIOR TO BEGINNING CARE.

I UNDERSTAND AND ACCEPT THAT THERE ARE RISKS ASSOCIATED WITH CHIROPRACTIC CARE AND GIVE CONSENT TO THE EXAMINATION THE DOCTORS DEEM NECESSARY AND THE CHIROPRACTIC CARE, INCLUDING SPINAL ADJUSTMENTS, AS REPORTED FOLLOWING MY ASSESSMENT.

Print Name_____

Signature_____ Date_____

IF PRACTICE MEMBER IS A MINOR/CHILD, PARENT OR GUARDIAN MUST SIGN BELOW.

Signature of Guardian_____

Relationship to Minor_____Date_____

Witness_____Date_____

LIFTED CHIROPRACTIC
ADVANCED BENEFICIARY NOTICE (ABN)

The purpose of this form is to help you be aware of chiropractic services in this office as it relates to any medical insurance you may have. Chiropractic care in this office is not focused on diagnosis of or relief of symptoms; it is centered on the location, analysis, and correction of underlying vertebral subluxations. Because of this, all services are coded in a manner which insurance carriers view as maintenance or wellness care and most likely will not be covered. Signing below signifies that you want the services provided in this office, 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 and policies as it relates to insurance coverage, not an official Medicare or other insurance carrier's stance or decision. Signing below indicates you have received and understand this notice.

Date_____

Print Name_____

Signature_____

Parent/Guardian_____