



Harbor Bay
CLINIC OF
CHIROPRACTIC

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PEDIATRIC INTAKE FORM

Build A Healthy Foundation.

Welcome to Harbor Bay Clinic of Chiropractic!

(For any question that does not apply to you, simply respond "N/A" for Not Applicable.)

Today's Date: _____

Have you ever received chiropractic care? No Yes, (Name of Doctor): _____

PERSONAL INFORMATION

Child's Full Name: _____

Child's Preferred Name: _____

Male Female

Weight: _____ lb. _____ oz. Height: _____ ft. _____ in.

Date of Birth: _____ Age: _____

Address: _____

City: _____ State: _____

Zip: _____

List Your Child's Regular Physical Activities:

List Your Child's Hobbies & Interests:

List The Name(s) & Age(s) of Your Child's Sibling(s):

Full Name of Parent/Guardian #1:

Phone: _____ Home Work Cell

Email: _____

Occupation: _____

Employer: _____

Full Name of Parent/Guardian #2:

Phone: _____ Home Work Cell

Email: _____

Occupation: _____

Employer: _____

Family Member(s) Responsible For Finances:

Parent/Guardian #1 Parent/Guardian #2

Both Parents/Guardians #1 & #2

Other: _____

Other's Phone #: _____

I wish to be called at home work cell other (check all that apply) regarding my child's care.

I do , I do not give permission to leave relevant medical information on my answering machine or voice mail.

I do , I do not want relevant medical information shared with the person who may answer the telephone.

The name(s) of the individual(s) with whom you may leave pertinent information are:

INSURANCE INFORMATION

Method of Payment: Cash Check Credit Card (V, MC, Disc, AmEx) Do you have Medicare? Y N

Insurance. Primary: _____ Secondary: _____

HEALTH GOALS

Check all of the current health and lifestyle goals for your child:

Improve Posture

Get Adequate Sleep

Drink More Water

Increase Energy

Improve Diet/Nutrition

Improve Focus/Concentration

Increase Self Confidence

Restore Emotional Health

Strengthen Immune System

Maintain Healthy Body Weight

Improve Athletic Performance

Other: _____

CASE HISTORY

Has your child ever had an operation? No Yes, (List all operation(s) including the year): _____

Has your child ever had a serious illness or health emergency? No Yes, (List all condition(s) including the year): _____

Does your child have any genetic disorders or disabilities? No Yes, (Explain): _____

Does your child have any allergies? No Yes, (Explain): _____

Has your child ever been in an auto accident? No Yes, (Include the year): _____

Has your child ever been unconscious? No Yes, (Explain): _____

Has your child ever fractured a bone? No Yes, (Explain): _____

Has your child ever taken an antibiotic drug? No Yes, (Include times per lifetime): _____

Is your child taking any over-the-counter or prescription drug, vitamin / supplement, or natural remedy?

No Yes, (Please list the name & reason for taking): _____

PRENATAL HISTORY

Complete this section if your child is YOUNGER than 5 years of age.

Name of Obstetrician / Midwife: _____

Ultrasounds during pregnancy? No Yes, (How many?): _____

Complications during pregnancy / delivery? No Yes, (Explain): _____

List any drug / medication, vitamin / supplement, or natural remedy taken during pregnancy / delivery: _____

Location of birth: Hospital Birthing Center Home Other: _____

Childbirth delivery method: Vaginal Planned Cesarean Section Emergency Cesarean Section

Vaginal Birth After Cesarean Vacuum Extraction Forceps

Birth Weight: _____ Birth Length: _____ APGAR Scores: _____ - _____

Was / is your child breast fed? No Yes, (For how long?): _____

Was / is your child formula fed? No Yes, (For how long?): _____ Formula type: _____

Was your child introduced to cow's milk? No Yes, (At what age?): _____

According to the National Safety Council, approximately 50% of children fall head first from a high place during their first years of life (i.e. a bed, changing table, down stairs) Did your child have a fall similar to this?

No Yes, Explain: _____

CURRENT SYMPTOMS

Select which is true for your child:

My child **DOES NOT** have symptoms. I am seeking chiropractic care to maintain wellness.

(If checked, move ahead to the "INITIAL ASSESSMENT" section)

My child **DOES** have symptoms.

Check all of the symptom(s) that has you seeking chiropractic care for your child:

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> ADHD/ADD | <input type="checkbox"/> Autism | <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Restless Sleep |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Back Pain | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Scoliosis |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Bed Wetting | <input type="checkbox"/> Growing Pains | <input type="checkbox"/> Temper Tantrums/Moody |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Colic | <input type="checkbox"/> Headaches | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Athletic Injury | <input type="checkbox"/> Digestive Problems | <input type="checkbox"/> Recurring Colds/Fevers | _____ |

When did your child's symptom(s) begin? Today Days Ago Weeks Ago Months Ago Years Ago

Did your child's symptom(s) begin as a result of an injury? No Yes, (Explain): _____

What have you already tried that **HAS NOT** helped to relieve your child's symptom(s)? _____

What have you already tried that **HAS** helped to relieve your child's symptom(s)? _____






INITIAL ASSESSMENT

NAME: _____ DATE: _____

Select which is true for your child.

- My child **DOES NOT** have symptoms. (If checked, move ahead to the "STRESS ASSESSMENT" section.)
 My child **DOES** have symptoms. (If checked, use the "EFFECT SCALE" to answer the "SELF RATING" questions.)

EFFECT SCALE

				
0	1 2 3	4 5 6	7 8 9	10
NO EFFECT	MILD EFFECT	MODERATE EFFECT	LIMITING EFFECT	SEVERE EFFECT
I am free from any symptom. I can do all of my daily activities. My quality of life is good. I am grateful for my good health.	I barely notice the symptom. I can do most of my daily activities. I don't think much about the symptom, but it does cause me some discomfort.	I notice the symptom and it causes me distress. I can do some of my daily activities. I can only ignore the symptom for a short period of time.	I experience constant distress from the symptom. I am unable to do many of my daily activities. I can not ignore the symptom, it disrupts my ability to think clearly, hold a job, and maintain social relationships.	I am in distress and excruciating pain from the symptom. I am unable to do any of my daily activities. I am weak, delirious and bedridden. (Very few people ever experience this level of pain. Suicide is often considered.)

SELF RATING

What is your child's main symptom for seeking chiropractic care? Write it here: _____

For each statement below, place an "X" in the "RATING" box to best show how the symptom effects your child.	RATING										
	0	1	2	3	4	5	6	7	8	9	10
ON AVERAGE, rate the effect of your child's symptom.											
RIGHT NOW, rate the effect of your child's symptom.											
AT ITS BEST, rate how close to "0" your child's symptom gets.											
AT ITS WORST, rate how close to "10" your child's symptom gets.											

If your child has a second symptom for seeking chiropractic care, write it here: _____

For each statement below, place an "X" in the "RATING" box to best show how the symptom effects your child.	RATING										
	0	1	2	3	4	5	6	7	8	9	10
ON AVERAGE, rate the effect of your child's symptom.											
RIGHT NOW, rate the effect of your child's symptom.											
AT ITS BEST, rate how close to "0" your child's symptom gets.											
AT ITS WORST, rate how close to "10" your child's symptom gets.											

* If your child has more than 2 symptoms, simply ask a team member for another form.

STRESS ASSESSMENT

Check all of the stresses your child has experienced in the past 3 months:

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Slip / Falls | <input type="checkbox"/> Poor Diet / Nutrition | <input type="checkbox"/> Lack of Sleep | <input type="checkbox"/> Emotional Stress |
| <input type="checkbox"/> Car Accident | <input type="checkbox"/> Excessive Sitting | <input type="checkbox"/> Death of A Loved One | <input type="checkbox"/> Occupational Stress |
| <input type="checkbox"/> Sports Injury | <input type="checkbox"/> Excessive Standing | <input type="checkbox"/> Hospitalization | <input type="checkbox"/> Financial Stress |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Lack of Exercise | <input type="checkbox"/> Surgery / Operation | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Increase of Exercise | <input type="checkbox"/> Change In Medication | _____ |

FAMILY HEALTH HISTORY

Place an "X" in the box below to show if your child's family members have ever had the following conditions.

- If there is more than one family member per category, use an "X" to represent each individual.
- If you are filling this form out for your child, use "SELF" to represent your child's conditions.

CONDITION	SELF	SPOUSE	SON(S)	DAUGHTER(S)	FATHER	MOTHER	SIBLING(S)
Acid Reflux/GERD							
ADD/ADHD							
Anxiety							
Arthritis/Joint Pain							
Asthma/Allergies							
Autoimmune Disease							
Bed Wetting							
Birth Defect							
Cancer							
Colic							
Convulsions/Epilepsy							
Deceased							
Depression/Mood Changes							
Diabetes							
Digestive Problems							
Ear Problems/Hearing Loss							
Fibromyalgia/Muscle Pain							
Frequent Cold/Flu							
Gall Bladder Problems							
High/Low Blood Pressure							
HIV/AIDS							
Impotence/Sexual Dysfunction							
Kidney Problems							
Learning Disability							
Liver Problems							
Menstrual Dysfunction							
Migraines							
Neck Pain/Back Pain/Disc Problems							
Prostate Problems							
Sciatica							
Scoliosis							
Sinus/Drainage Problems							
Skin Problems							
Sleep Problems							
TMJ Dysfunction							
Tongue or Lip Tie							
Thyroid Problems							
Tremors							
Vertigo/Dizziness							
Vision Problems							
Other:							

TERMS OF ACCEPTANCE

At Harbor Bay Clinic of Chiropractic the term Practice Member is used for those that have suffered either an injury or are seeking wellness rather than symptom management. A Practice Member is an active participant in his or her chiropractic care, and is therefore, invited to ask any questions or express any concerns that he or she may have. Practice members can expect quality service and leadership as they regain control of their health. First, a complete analysis of your spine will be administered to detect the presence of vertebral subluxations and to monitor your progress. Please read and sign this form stating that you understand the items explained below. If there is anything that is unclear please ask questions before you sign. If you refuse to sign this form the doctor reserves the right to refuse care.

INFORMED CONSENT FOR CHIROPRACTIC CARE

I hereby consent to give the doctor of chiropractic, and anyone working in the Harbor Bay Clinic of Chiropractic office, authorized by the chiropractor, permission and authority to care for my child (the minor listed here: _____ for whom I am legally responsible). Chiropractic tests, diagnosis, analysis and adjustments are very safe and beneficial. However, in rare cases, underlying physical defects, deformities or pathologies may make an individual more prone to injury. It is the responsibility of the child's parent/guardian to make it known, or to learn through health care procedures if your child is suffering from latent pathological defects, illnesses, or deformities, which would otherwise not come to the attention of the chiropractor. The doctor of chiropractic will not give any treatment or care if she or he is aware that such care should not be used for a particular condition or circumstance. Your child's doctor of chiropractic is a licensed primary care provider, and is able to work with all other types of providers. I understand that if my child accepted as a Practice Member at Harbor Bay Clinic of Chiropractic, I am authorizing them to proceed with any treatment that they deem necessary. I understand that following the doctor's recommended care plan is essential to maximizing my child's healing and reaching optimal health through chiropractic. Furthermore, any questions that I have regarding chiropractic care, will be explained to me upon my request.

AUTHORIZATION FOR X-RAYS

Specific postural x-rays may be necessary for the identification of the location, type, and severity of any vertebral subluxations, as well as for the diagnosis and identification of latent or dangerous conditions requiring medical attention. X-rays may also be used to show progress after a period of recommended chiropractic care. **At your request, you can receive a copy of your x-rays to a disc for the mandated fee of \$5.00.**

By signing below, I authorize Harbor Bay Clinic of Chiropractic to perform diagnostic x-rays of my child if medically necessary.

Select which is true for your female child:

- To the best of my knowledge, there is no chance that my child is pregnant at this time.
- I know or believe that my child may be pregnant at this time and therefore **I DO NOT** authorize Harbor Bay Clinic of Chiropractic to perform diagnostic x-rays of her.

AUTHORIZATION FOR RELEASE OF INFORMATION & ASSIGNMENT OF BENEFIT

By signing below, I recognize that I am financially responsible for all services rendered to my child regardless of insurance or benefits. I further understand that any health insurance policy is an arrangement between me and my child's insurance carrier and that I may be required to pay for some or all of the fees charged to my child's account. I hereby authorize Harbor Bay Clinic of Chiropractic LLC to release all necessary information concerning my child's health condition to any billing company, insurance company, attorney, and/or adjuster in order to process any claim for reimbursement of charges incurred by my child. In addition I authorize Harbor Bay Clinic of Chiropractic LLC to release any information regarding my child's health condition to other health care providers involved in my child's care. This assignment will remain in effect until revoked by me in writing. I agree that a photocopy of this form is to be considered as valid as the original. I confirm that all information I have provided is true and correct to the best of my knowledge. I confirm that I have read and fully understand this agreement and authorize Harbor Bay Clinic of Chiropractic LLC to proceed with Chiropractic tests, diagnosis, analysis and adjustments.

NOTICE OF PRIVACY PRACTICES

This notice describes how health information about your child may be used and disclosed and how you can get access to your child's health information and records.

Harbor Bay Clinic of Chiropractic LLC, understand the importance of privacy and we are committed to maintaining the confidentiality of your child's protected health information (PHI) in compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). We have developed office policies and procedures that protect your child's personal and health information when used within our office and any devices used to copy or transfer this data. We assure you that your child's information will only be shared as required and only for the purpose of administering your child's case and obtaining payment for services. Be assured that without your permission, your child's health information will not be used for any other purpose.

The following ways are how your child's PHI may be used within our office to provide the best care and services possible:

- To provide treatment, obtain payment, and conduct health care operations.
- To schedule appointments and send reminders.
- To communicate with your child's family, friends, and/or caregivers with your authorization.
- As permitted or required by the law.

The following describes your rights regarding your child's PHI. You may:

- Request to inspect any copy of your child's records.
- Request to amend incomplete or inaccurate information in your child's records.
- Receive an accounting of certain disclosures of your child's health information.
- Ask for additional privacy protections (although your request may be declined).
- Receive a paper copy of this notice.

Harbor Bay Clinic of Chiropractic LLC, reserves the right to change this privacy policy as allowed by law and to make the new notice apply to health information already received as well as any information received in the future. A copy of our current notice is available upon request. The notice will display the effective date.

If you believe that we have not properly respected the privacy of your child's PHI, you may notify our office by calling (301) 373-3731, sending a letter to our office address or by emailing info@harborbaychiropractic.com.

I confirm that I have received and reviewed this notice and understand how health information about my child may be used and disclosed and how I can get access to my child's health information and records.

Signature of Practice Member

Date

SOCIAL MEDIA CONSENT

Select an option below.

I **DO** authorize Harbor Bay Clinic of Chiropractic to display testimonials, photographs and videos of my child in the office or on social media outlets. I understand that the purpose of sharing this information is to provide others with chiropractic education and give hope to those seeking answers to their health concerns. My consent remains in effect until revoked by me in writing.

I **DO NOT** authorize Harbor Bay Clinic of Chiropractic to display testimonials, photographs and videos of my child in the office or on social media outlets at this time.