Chiropractic Intake and History

children and youth

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Personal Information:

Name: ______________________________ Birth Date: ____________________

Address: ____

Home Phone: ____________ Cell Phone: ____________ Email: ____________________

Sex: **M F O:** ____ Gender: ____________________ Age: __________

Preferred Pronoun: ____________________ Height: __________ Weight: __________

Primary Care Physician name and contact information:

____

In case of Emergency, Contact:

Name(s): ____

Relationship to patient: ____

Contact Information: ____

Insurance Information:

Is the reason that your child is consulting this office the result of an auto accident? **Y N**

If Yes, please provide the name of the insurance company involved, contact information and claim number:

____

Is your child currently covered by health insurance? **Y N**

Name of health insurance company: ____

Name of primary policy holder: ____

Birth date of primary: ______________ Address of primary: ____________________

____

Relationship to patient: ____________________

Are you aware of whether there is a deductible or copay that applies? If so, please list that information:

____

Current History:

What prompted your visit here today? ____________________

What would you like to see change through your child's care in this office? ____________________

What would be different in your child's life if this were to change? ____________________

Please use the scale below to describe your child's state of health:

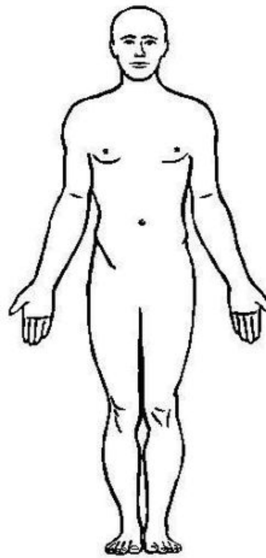
Excellent Good Fair Getting Better Getting Worse

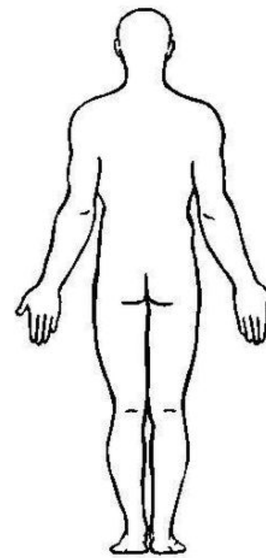
Please mark the areas on the pictures to show where you are having symptoms.

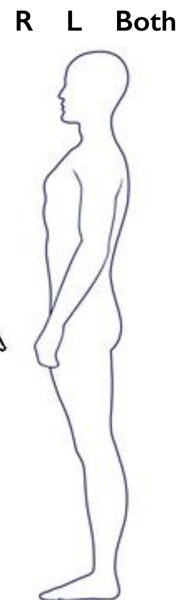
What does it feel like? (check all that apply)

- O Numbness
- O Dull
- O Cramping
- O Burning
- O Swelling
- O Tingling
- O Aching
- O Nagging
- O Throbbing
- O Stiffness
- O Sharp
- O Shooting
- O Stabbing
- O Hot
- O Cold
- O Other: ____________________ ____________________

R L Both







Please use the scale below to describe the intensity of your child's symptoms:

No Pain Mild Pain Moderate Pain Severe Pain Extreme Pain

Please check any of the following activities that your child is having difficulty with due to their health:

- O Sleep
- O Sit
- O Stand
- O Change Positions
- O Lift and Carry
- O Drive
- O Travel
- O Walk
- O Exercise
- O Maintain Relationships
- O Care for Self and Others
- O Perform Household Chores
- O Concentrate
- O Participate in school/complete school work
- O Engage in Usual Recreation (Kids: Play)
- O Other: ____________________ ____________________

Comments: ____________________
____
____

Is there anything in your child's daily life that you believe is worsening their symptoms and/or state of health?

Is there anything in your child's daily life that you believe is improving their symptoms and/or state of health?

Is your child currently receiving treatment for any of these symptoms? **Y N**

If yes, what type of treatment are they receiving?

What have been the results of that treatment?

Has your child received chiropractic care before? **Y N**

Is there anything you would like me to know about your experiences with chiropractic?

Lifestyle and Environmental History:

What activities does your child regularly participate in? (ie recreation, sports, music, dance, etc…)

Is your child exposed to any chemical fume, dust, powder or smoke for prolonged periods? **Y N**

Please list any medications that your child is currently taking: (both prescription and over-the-counter):

Medication Name	To Treat	For how long?

Was your child previously taking any medications regularly? (If yes, please list):

Please mark all that apply and give details where applicable:

- O Use a phone or tablet device more than 90 min/day
- O Have extensive dental or orthodontic work being performed
- O Experience stress that is hard to manage
- O Experience lack of energy or fatigue
- O Have trouble sleeping
- O Have had an automobile accident:
- O Have had a concussion:
- O Had surgery of any kind:
- O Had any complications at birth:
- O Had any other health complications:

Review of Systems:

Please check all that have applied to your child in the past and circle those which currently apply to them.

- Fatigue
- General Weakness
- Fever or Chills
- Recent Weight Change
- Cancer

- Eye Disease or Injury
- Blurred or Double Vision
- Other Eye Problem

- Hearing Loss or Ringing in Ears
- Ear Infections
- Vertigo
- Sinus Problems
- Nose Bleeds
- Loss of Smell
- Mouth Sores
- Difficulty Swallowing
- Swollen Glands in Neck

- Heart Disease
- Chest Discomfort
- Palpitations
- Shortness of Breath
- Swelling in Feet, Ankles or Hands
- High or Low Blood Pressure

- Chronic or Frequent Coughing
- Asthma or Wheezing
- Blood in Sputum

- Loss of Appetite
- Change in Bowel Movements
- Diarrhea or Constipation
- Nausea or Vomiting
- Blood in Stool
- Abdominal Pain
- Ulcer
- Heartburn

- Joint Pain, Stiffness or Swelling
- Weakness of Muscles or Joints
- Muscle Pain or Cramps
- Back or Neck Pain
- Cold Extremities
- Difficulty Walking

- Memory Loss or Confusion
- Anxiety or Depression
- Difficulty Sleeping
- Difficulty Concentrating

- Headaches
- Dizziness
- Seizures or Convulsions
- Pins and Needles
- Numbness
- Tremors or Shaking
- Paralysis
- Stroke
- Head Injury
- Loss of Balance or Dexterity

- Urinary Problems
- Kidney Stones
- STDs
- Pain in Genitals
- Menstrual Pain
- Menstrual Irregularity
- Miscarriages

- Skin Rash or Itching
- Skin Lesions
- Hair or Nail Changes

- Glandular/Hormone Problem
- Thyroid Disease
- Diabetes
- Breast Pain, Lump or Discharge
- Excessive Thirst or Urination
- Heat or Cold Intolerance

- Slow to Heal after Cuts
- Frequent Bleeding or Bruising
- Anemia
- Blood Transfusions
- Enlarged or Painful Glands

- Frequent Illness
- Environmental Allergies
- Food Allergies
- Drug Allergies
- Other Allergies

Consent to evaluate and adjust a minor:

I, ______________________________, being the parent or legal guardian of ____________________, have read and fully understand the Statement of Purpose and Statement of Privacy Practices and hereby grant permission for my child to receive chiropractic care at RiverSide Chiropractic LLC.

____________________________________	________________________________	__________
Signature of parent or guardian	Relationship to patient	Date

Is it ok to leave messages for you regarding your child's appointments at this office at the phone numbers you provided? **Y** **N** If **No**, how would you like to be contacted?

____

Cancellation Policy:

_____ I understand that 24 hours notice must be given for all cancellations except in case of extenuating circumstances or I may be billed for the missed appointment.

Financial Policy:

Payment is expected at the time that services are rendered including all copays and coinsurance unless prior arrangements have been made.

Medicare and other health insurance plans do not pay for maintenance care or wellness visits for chiropractic. On the day of service, the usual charge for a wellness visit is $45.

Medicare and medicaid do not pay for chiropractic exams or evaluations or for adjunctive therapies. On the day of service, the usual charge for a 30-minute chiropractic initial exam is $60. Other therapies that might not be covered cost between $20 - $60.

If your insurance plan does not pay for a service because it is a non-covered service, you will be responsible for that charge. Please select only ONE from the three options below by initialing in the space provided:

_____ You would like to be provided with the services that may not be covered by your insurance plan and you will be asked to pay for those services. You would also like RiverSide Chiropractic to submit a claim to your insurance company even if they are not expected to pay.

(This makes it possible for you to file an appeal with your insurance company.)

_____ You would like to be provided with the services that may not be covered and you do not want RiverSide Chiropractic to submit a claim to your insurance company.

(This means you will not be able to file an appeal with your insurance company.)

_____ You would not like to be provided with the services that may not be covered.

____________________	____________________	________
Print Name	Signature	Date

To be completed by chiropractor:		
CC:		
O:		Q:
S:		T:
Rad:	Pro:	
Ref:	Pal:	
Notes:		
AC:		
O:		Q:
S:		T:
Rad:	Pro:	
Ref:	Pal:	
Notes:		
AC:		
O:		Q:
S:		T:
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Notes:		