

STERN CHIROPRACTIC



Pediatric Intake Form

Child's Name: _____ Birth Date: _____ Age: _____ Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Child's SS#: _____ - _____ - _____ Sex: _____ Parents Names: _____

Please check the phone number(s) where we may contact you/leave a message:

Home: () _____ Cell: () _____ Work: () _____

Email: _____ Siblings (Names/Ages): _____

Reason for today's visit: _____

Whom may we thank for referring you? _____

Family Doctor's Name: _____ Phone: () _____

Family Doctor's Address: _____

Would you like me to keep your family doctor informed about your treatment? Yes No

I have completed the above information to the best of my knowledge. I authorize Stern Chiropractic to release any information concerning my child's health and health care services to my insurance companies. A photocopy of this authorization is to be considered as valid as original. This authorization will remain in effect until revoked by me in writing. I understand I am financially responsible for all charges and fees.

Signature of Parent/Guardian

____/____/____
Date



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Pediatric Health History



Why is this form important?

As a family chiropractic office, we focus on your child’s ability to be healthy. Our goals are first to address the issues that brought you to this office, and second, to offer you and your child the opportunity of improved health potential and wellness services.

Addressing the issues that brought you to our office

If your child has no symptoms or complaints, and is here for wellness services, please check []; otherwise please briefly describe the problem (what’s wrong, what part of his/her body) including how it is affecting your child.

When did it start? _____ How did it happen? _____

If he/she is experiencing pain, is it: [] Sharp [] Dull [] Travels [] Comes and Goes [] Constant?

Since the problem started, is it: [] About the same [] Getting worse [] Getting better?

What makes it worse? _____ What makes it better? _____

It interferes with: [] School [] Sleep [] Walking [] Sitting [] Activities/other: _____

Have you seen anyone else for this problem: _____

List any medical conditions: _____

List all medications your child is taking: _____

List all surgeries your child has had: _____

List all vitamins and supplements your child is taking: _____

Daily, we experience physical, chemical and emotional stresses that can accumulate and result in serious loss of health potential. Most times, the effects are gradual and begin very early in life. Answering these questions will give us information that will allow us to better assess the challenges to your child’s health potential.



Pregnancy:

of previous pregnancies: _____ Where there any problems? _____

Were there any complications during the pregnancy? _____

Was mom on any medications, prescription or over-the-counter? [] Yes [] No Why? _____

Did mom or dad smoke during pregnancy? [] Yes [] No Who? _____

Was the baby ever in the Breech position? [] Yes [] No How Many Ultra Sounds were performed? _____

Duration of Gestation: _____ weeks

Birth and Delivery:

Where was the baby born? [] Home [] Hospital [] Birthing Center [] Other: _____

Was the delivery: [] Vaginal [] C-section If not vaginal, why? _____

Were any devices used? [] Forceps [] Vacuum APGAR Scores: Initial _____ 5 minutes _____

How long was the labor? _____ How long was the delivery? _____ Any problems? _____

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Was labor induced with medications? yes No Was an epidural administered? Yes No

Any evidence of birth trauma: bruises, odd shaped head, stuck in burth canal, fast or excessively long birth, respiratory depression, cord around neck, other Yes No If yes, describe: _____

Infancy:

Is/was the baby breastfed? Yes No If yes, how long?_____ Any problems?_____

Was the infant vaccinated? Yes No If yes, any problems?_____

Was there any immediate or ongoing medical care or use of medicines? Yes No If yes, what?_____

Did the infant suffer any traumas i.e. falls or car accidents? Yes No

Did the baby meet all developmental milestones? Yes No Explain:_____

Has the infant been under regular chiropractic care? yes No

Childhood Years:

Did the child meet all developmental milestones? Yes No Explain:_____

Did the child have any childhood illnesses? Yes No Explain:_____

Does the child play sports? Yes No Which sports:_____

Has the child had any surgery? Yes No Explain:_____

Has the child fallen from a height over 3 ft.? Yes No Explain:_____

Was the child involved in any car accidents? Yes No Explain:_____

Has there been any prolonged use of meds? Yes No Explain:_____

Has the child suffered emotional traumas? Yes No Explain:_____

Has the child had any behavioral problems? Yes No Explain:_____

Please give us any other health information you feel would be helpful:_____

The statements made on this form are accurate to the best of my knowledge and I request and give consent to this office to examine and provide chiropractic care to my child.

Signature of Parent or Guardian

____/____/____
Date

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Practice Member's Name: _____ Date: _____

Health History Questionnaire

Please put a (√) next to conditions you have currently and a "P" for conditions you have had in the past.

<p>General</p> <p>1 ___ Fever 2 ___ Chills 3 ___ Night Sweats 4 ___ Loss of Sleep 5 ___ Fatigue 6 ___ Nervousness 7 ___ Weight Loss/Gain 8 ___ Allergies 9 ___ Bleeding Problems 10 ___ Anemia 11 ___ Diabetes 12 ___ Cancer 13 ___ Thyroid Disease 14 ___ High Cholesterol 15 ___ Osteoporosis 16 ___ Alcoholism 17 ___ Drug Abuse</p> <p>Eyes, Ears, Nose, & Throat</p> <p>18 ___ Poor Vision 19 ___ Pain in Eye(s) 20 ___ Deafness/Difficulty Hearing 21 ___ Nosebleeds 22 ___ Nose Problems 23 ___ Sinus Trouble 24 ___ Dental Problems 25 ___ Hoarseness</p> <p>Gastrointestinal</p> <p>26 ___ Poor Appetite 27 ___ Poor Digestion 28 ___ Difficulty Swallowing 29 ___ Belching or Gas 30 ___ Frequent Nausea 31 ___ Vomiting Blood 32 ___ Pain over Abdomen 33 ___ Ulcer 34 ___ Black or Bloody Stool 35 ___ Liver Problems 36 ___ Gall Bladder Problems 37 ___ Jaundice 38 ___ Hernia 39 ___ Diarrhea 40 ___ Constipation 41 ___ Hemorrhoids 42 ___ Appendicitis</p> <p>Respiratory</p> <p>43 ___ Difficulty Breathing 44 ___ Chronic Cough 45 ___ Coughing-up Phlegm 46 ___ Coughing-up Blood 47 ___ Wheezing/Asthma 48 ___ Pneumonia 49 ___ Tuberculosis</p>	<p>Cardiovascular</p> <p>50 ___ Irregular Heartbeat 51 ___ High Blood Pressure 52 ___ Pain in Chest 53 ___ Heart Trouble 54 ___ Ankle Swelling 55 ___ Varicose Veins 56 ___ Stroke</p> <p>Genitourinary</p> <p>57 ___ Frequent Urination 58 ___ Painful Urination 59 ___ Blood in Urine 60 ___ Urinary Infection 61 ___ Kidney Disease 62 ___ Inability to Control Urine 63 ___ Difficulty Starting Urine Flow 64 ___ Get up Frequently at Night to Urinate 65 ___ Breast Lumps or Pain 66 ___ Venereal Disease 67 ___ Sexual Dysfunction</p> <p>Skin</p> <p>68 ___ Itching/Dry Flaky 69 ___ Bruising Easily 70 ___ Change in Mole(s) 71 ___ Skin Cancer</p> <p>Male Only</p> <p>72 ___ Testicular Swelling/Pain 73 ___ Prostate Problems</p> <p>Female Only</p> <p>74 ___ Painful Periods 75 ___ Excessive Flow 76 ___ Irregular Cycles 77 ___ Vaginal Burning/Itching 78 ___ Hot Flashes 79 ___ Date Last Period Began _____ 80 ___ Date of Last PAP Test _____</p> <p>Neurological</p> <p>81 ___ Weakness 82 ___ Twitching 83 ___ Tremors 84 ___ Headaches 85 ___ Fainting 86 ___ Dizziness 87 ___ Convulsions 88 ___ Epilepsy 89 ___ Numbness/Tingling 90 ___ Arm/Leg Pain 91 ___ Mental Disorder</p>	<p>Musculoskeletal</p> <p>92 ___ Neck Stiffness/Pain 93 ___ Pain Between Shoulder Blades 94 ___ Low Back Pain 95 ___ Swollen Joints 96 ___ Stiff/Painful Joints 97 ___ Muscle Aches/Soreness 98 ___ Spinal Curvature 99 ___ Arthritis</p> <p>Habits/Exercise</p> <p>100 ___ Smoking _____ packs/day 101 ___ Alcohol _____ drinks/week 102 ___ Recreational Drug Use 103 ___ Times per week you exercise _____</p> <p>Family Medical History</p> <p>Include information on brothers, sisters, parents and grandparents (not yourself)</p> <p>104 ___ Diabetes 105 ___ Thyroid Disease/Goiter 106 ___ Kidney Disease 107 ___ High Blood Pressure 108 ___ Heart Disease 109 ___ Cancer 110 ___ Muscle, Bone or Nerve Disease 111 ___ Other _____ _____ _____</p> <p>Other</p> <p>112 List any medical conditions you have (even if listed above): _____ _____ _____ _____ _____</p> <p>113 List all Surgeries/Hospitalizations you have had: _____ _____ _____ _____</p> <p>114. list all Vitamins/Supplements/Herbs you are currently taking: _____ _____ _____ _____</p>
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115. Please list all medications you are currently taking and why you are taking them: _____

Stern Chiropractic Office Policies

Welcome to Stern Chiropractic - Stern Chiropractic would like to provide you with the best possible care. Dr. Stern will conduct a thorough history and physical examination to decide if he can assist you. If Dr. Stern does not believe that your condition will respond to chiropractic and/or acupuncture care, he will refer you to another health care provider, if appropriate.

Fee and Payment Policy - Payment is due in full at time of service. The office accepts cash (please try to have exact change), personal check and charge (Visa & MC). The office charges \$25 for any returned check. If fees for service are not paid in a timely manner, a late payment penalty (ies) will be assessed. If you (the patient) do not pay your bill on a timely basis and the office must pursue collections efforts, you will be responsible for all fees associated with said collections. There is a \$20 minimum for credit card charges.

Cancellation Policy – Please notify the office as soon as possible if you will be unable to keep your appointment. Appointments not cancelled at least 24 hours in advance will be billed to the patient/responsible party at the value of the visit missed.

Payment Agreement

I (the patient/responsible party) understand that I am responsible for all charges in full at the time of service and if I do not pay my bill on a timely basis, I will be financially responsible for all charges and fees associated with late payment.

Insurance

This office will provide you with the appropriate billing information for you to submit to your insurance company for reimbursement.

The following signature demonstrates an understanding and acceptance of the office policies of Stern Chiropractic.

Practice Member/Guardian (if applicable) Signature

Date

Stern Chiropractic reserves the right to change office policies as needed without notice.

STERN CHIROPRACTIC, LTD.

**PATIENT CONSENT
FOR USE AND/OR DISCLOSURE OF
PROTECTED HEALTH INFORMATION
TO CARRY OUT TREATMENT, PAYMENT
AND HEALTHCARE OPERATIONS**

_____, hereby states that by signing this Consent, I acknowledge and agree as follows:

1. Stern Chiropractic’s Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information (“PHI”) necessary for Stern Chiropractic to provide treatment to me, and also necessary for Stern Chiropractic to obtain payment for treatment and to carry out health care operations. Stern Chiropractic explained to me that the Privacy Notice will be available to me in the future at my request. Stern Chiropractic has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.
2. Stern Chiropractic reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.
3. I understand that, and consent to, the following appointment reminders, communications from this office, birthday greetings, recall notice, billing statements and newsletters that will be used by Stern Chiropractic: a) a postcard or letter mailed to me at the address provided by me; b) telephoning my home and leaving a message on my answering machine or with the individual answering the phone; and c) emailing me at the email address provided by me.
4. Stern Chiropractic may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for Stern Chiropractic to treat me and obtain payment for that treatment, and as necessary for Stern Chiropractic to conduct its specific health care operations.
5. I understand that I have a right to request that Stern Chiropractic restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, Stern Chiropractic is not required to agree to any restrictions that I have requested. If Stern Chiropractic agrees to a requested restriction, then the restriction is binding on Stern Chiropractic.
6. I understand that this Consent is valid for seven years. I further understand that I have the right to revoke this Consent, in writing, at any time for all *future* transactions, with the understanding that any such revocation shall not apply to the extent that Stern Chiropractic has already taken action in reliance on this consent.
7. I understand that if I revoke this consent at any time, Stern Chiropractic has the right to refuse to treat me.
8. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then Stern Chiropractic will not treat me.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

Name of Individual (Printed)

Signature of Individual

Signature of Legal Representative
(e.g., Attorney-In-Fact, Guardian, Parent if a minor):

Relationship

Date Signed ____/____/____

Witness: _____