



Pediatric Intake Form (Birth to 12 years)

Date: ___/___/___
Child's Name: _____ DOB: ___/___/___
Parent's/Guardian's Names: _____
Phone numbers: (H) _____ (C) _____ Best number to reach you? H C
Address: _____
E-Mail Address: _____@_____
Has your child been checked by a Doctor of Chiropractic? Yes No Name: _____
Were x-rays taken? Yes No Who is your medical pediatrician? _____

Prenatal History

Is your child adopted? Yes No
Did you have any complications and when? _____
Did you smoke/consume alcohol? Yes No
Did you take medication? Yes No Reason: _____

Birth history

Did you have ultrasound during this pregnancy? Yes No Frequency _____
Place of birth: Home/ Birthing Center/ Hospital
Provider: Midwife OB-Gyn/ Other (Name): _____
Type of Birth: Vaginal / C-section. Were pain medications used? Yes No Type _____
Was labor induced? Yes No If yes, why? _____
What position did you deliver in: Squatting On Back Other _____
Birth Trauma: Doctor assisted Twisting and/or Pulling Vacuum Extraction Forceps
Newborn trauma (medical procedures and tests): _____
APGAR score: at birth ___/10 at 5-minutes ___/10 Unsure
Did your child have a misshaped skull/head? Yes No Purple markings on their face? Yes No

Do you/Did you breastfeed your child? Yes No If yes, for how long? _____
Does your child prefer one breast/side over the other? Yes No Side: Right Left
Does your child have any food or other allergies? (list) _____

Has your child been immunized according to the recommended schedule? Yes No
Reason for vaccination: informed decision, didn't know had a choice, recommended
Did your child have any negative reactions to vaccinations? Yes No _____
Were they reported? Yes No

Has your child ever had any surgeries? Yes No Please explain: _____
Have they been on antibiotics? Yes No How many times? _____ Reason: _____
Is your child currently taking any meds? Yes No _____
Any vitamins? Yes No _____

Baby/Toddler (0-4): have/did any of the following occur?

<input type="checkbox"/> Fall from a changing table	<input type="checkbox"/> Frequent crying spells
<input type="checkbox"/> Tumble down stairs	<input type="checkbox"/> Frequent fevers
<input type="checkbox"/> Fall out of crib	<input type="checkbox"/> Frequent bouts of diarrhea
<input type="checkbox"/> Involvement in MVA	<input type="checkbox"/> Constipation
<input type="checkbox"/> Fall off of playground equip	<input type="checkbox"/> Sleeping problems
<input type="checkbox"/> Play in a Johnny jumper	<input type="checkbox"/> Repeated infections or colds
<input type="checkbox"/> Frequent ear infections	<input type="checkbox"/> Colic
<input type="checkbox"/> Tonsillitis	<input type="checkbox"/> Inadequate weight gain
<input type="checkbox"/> Reaction to vaccines	<input type="checkbox"/> Other: _____

Please explain: _____

Child (5-12): have/did any of the following occur?

- Fall from a tree
- Fall on playground
- Fall off of a bicycle
- Hyperactivity/autism
- Sports accident
- Learning difficulties
- Car accident
- Asthma
- Stomach pains
- Allergies
- Scoliosis
- Leg/knee pains
- Bed wetting
- Other: _____

Please explain: _____

Which of the above bothers your child the most? _____

When did it begin? _____ Is it getting worse? Yes No

Is the pain: constant intermit cyclic

How much has the complaint affect daily activities/routines? Not at all Somewhat Frequently Always

Which sports does your child play? Soccer Football Gymnastics Karate Hockey Lacrosse

Basketball Dance Wrestling Baseball/ Softball Volleyball Tennis Swimming Rugby

Other: _____

How would you rate your child's diet? Well balanced Average High amounts sugar & processed food

Does your child consume artificial sweeteners? Yes No Flouridated water? Yes No

Number of hours your child sleeps? ____/day Quality: Good Fair Poor

Is there anything else we should know about your child? _____

Authorization to Treat a Minor

I, _____ the undersigning parent/person having legal custody/guardianship of _____, a minor, do hereby authorize, request and direct Drs. Skow and/or Murray and whomever he/she may designate as assistant to perform in judgment any examination and chiropractic diagnosis or treatment which is deemed necessary.

Any specific written authorization you provide may be revoked at any time by writing to us at the address provided at the end of this notice.

PATIENT: _____

Date of Birth: _____

Name (Print)

Social Security #: _____

Signature: _____

Date: _____

Parent/Legal guardian

Insurance Information

Insured's Name: _____

Date of Birth: ____/____/____ SS#: _____

Relationship to patient: _____

Insured's Employer: _____

Insurance Company: BC/BS (PPO) Medicare Coventry United Health Care Other: _____

Insurance ID#: _____

Group #: _____ Plan/Program: _____

Assignment and Release: I certify that I, and/or my dependent(s), have insurance coverage with above insurance company and assign directly to Valerie Skow/Lindsey Murray all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above named doctor/facility may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

SIGNATURE

PRINT

Name of Patient, Parent, Guardian or Personal Representative

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, have received a copy of this office's Notice of Privacy Practices. I understand that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the healthcare providers who may be directly and indirectly involved in providing my treatment.
- Obtain payment from third-party payors.
- Conduct normal healthcare operations such as quality assessments and accreditation.

{Please Print Name}

{Signature}

{Date}

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify) _____

Staff Signature

Date

HIPAA PRIVACY NOTICE

PLEASE REVIEW THIS NOTICE CAREFULLY. IT DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU MAY GAIN ACCESS TO THAT INFORMATION.

POLICY STATEMENT

This Practice is committed to maintaining the privacy of your protected health information ("PHI"), which includes information about your medical condition and the care and treatment you receive from the Practice and other health care providers. This Notice details how your PHI may be used and disclosed to third parties for purposes of your care, payment for your care, health care operations of the Practice, and for other purposes permitted or required by law. This Notice also details your rights regarding your PHI.

USE OR DISCLOSURE OF PHI

The Practice may use and/or disclose your PHI for purposes related to your care, payment for your care, and health care operations of the Practice. The following are examples of the types of uses and/or disclosures of your PHI that may occur. These examples are not meant to include all possible types of use and/or disclosure.

- **Care** – In order to provide care to you, the Practice will provide your PHI to those health care professionals directly involved in your care so they may understand your medical condition and needs and provide advice or treatment. For example, your physician may need to know how your condition is responding to the treatment provided by the Practice.
- **Payment** – In order to get paid for some or all of the health care provided by the Practice, the Practice may provide your PHI, directly or through a billing service, to appropriate third party payers, pursuant to their billing and payment requirements. For example, the Practice may need to provide your health insurance carrier with information about health care services you received from the Practice so the Practice may be properly reimbursed.
- **Health Care Operations** – In order for the Practice to operate in accordance with applicable law and insurance requirements and in order for the Practice to provide quality and efficient care, it may be necessary for the Practice to compile, use and/or disclose your PHI. For example, the Practice may use your PHI in order to evaluate the performance of the Practice's personnel in providing care to you.

AUTHORIZATION NOT REQUIRED

The Practice may use and/or disclose your PHI, without a written Authorization from you, in the following instances:

1. **De-identified Information** – Your PHI is altered so that it does not identify you and, even without your name, cannot be used to identify you.
2. **Business Associate** – To a business associate, who is someone the Practice contracts with to provide a service necessary for your treatment, payment for your treatment and/or health care operations (e.g., billing service or transcription service). The Practice will obtain satisfactory written assurance, in accordance with applicable law, that the business associate will appropriately safeguard your PHI.
3. **Personal Representative** – To a person who, under applicable law, has the authority to represent you in making decisions related to your health care.

4. Public Health Activities – Such activities include, for example, information collected by a public health authority, as authorized by law, to prevent or control disease, injury or disability. This includes reports of child abuse or neglect.
5. Federal Drug Administration – If required by the Food and Drug Administration to report adverse events, product defects, problems, biological product deviations, or to track products, enable product recalls, repairs or replacements, or to conduct post marketing surveillance.
6. Abuse, Neglect or Domestic Violence – To a government authority, if the Practice is required by law to make such disclosure. If the Practice is authorized by law to make such a disclosure, it will do so if it believes the disclosure is necessary to prevent serious harm or if the Practice believes you have been the victim of abuse, neglect or domestic violence. Any such disclosure will be made in accordance with the requirements of law, which may also involve notice to you of the disclosure.
7. Health Oversight Activities – Such activities, which must be required by law, involve government agencies involved in oversight activities that relate to the health care system, government benefit programs, government regulatory programs and civil rights law. Those activities include, for example, criminal investigations, audits, disciplinary actions, or general oversight activities relating to the community's health care system.
8. Judicial and Administrative Proceeding – For example, the Practice may be required to disclose your PHI in response to a court order or a lawfully issued subpoena.
9. Law Enforcement Purposes – In certain instances, your PHI may have to be disclosed to a law enforcement official for law enforcement purposes. Law enforcement purposes include: (1) complying with a legal process (i.e., subpoena) or as required by law; (2) information for identification and location purposes (e.g., suspect or missing person); (3) information regarding a person who is or is suspected to be a crime victim; (4) in situations where the death of an individual may have resulted from criminal conduct; (5) in the event of a crime occurring on the premises of the Practice; and (6) a medical emergency (not on the Practice's premises) has occurred, and it appears that a crime has occurred.
10. Coroner or Medical Examiner – The Practice may disclose your PHI to a coroner or medical examiner for the purpose of identifying you or determining your cause of death, or to a funeral director as permitted by law and as necessary to carry out its duties.
11. Organ, Eye or Tissue Donation – If you are an organ donor, the Practice may disclose your PHI to the entity to whom you have agreed to donate your organs.
12. Research – If the Practice is involved in research activities, your PHI may be used, but such use is subject to numerous governmental requirements intended to protect the privacy of your PHI such as approval of the research by an institutional review board, the de-identification of your PHI before it is used, and the requirement that protocols must be followed.
13. Avert a Threat to Health or Safety – The Practice may disclose your PHI if it believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to an individual who is reasonably able to prevent or lessen the threat.
14. Specialized Government Functions – When the appropriate conditions apply, the Practice may use PHI of individuals who are Armed Forces personnel: (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veteran Affairs of eligibility for benefits; or (3) to a foreign military authority if you are a member of that foreign military service. The Practice may also disclose your PHI to authorized federal officials for conducting national security and intelligence activities including the provision of protective services to the President or others legally authorized.

15. Inmates – The Practice may disclose your PHI to a correctional institution or a law enforcement official if you are an inmate of that correctional facility and your PHI is necessary to provide care and treatment to you or is necessary for the health and safety of other individuals or inmates.
16. Workers' Compensation – If you are involved in a Workers' Compensation claim, the Practice may be required to disclose your PHI to an individual or entity that is part of the Workers' Compensation system.
17. Disaster Relief Efforts – The Practice may use or disclose your PHI to a public or private entity authorized to assist in disaster relief efforts.
18. Required by Law – If otherwise required by law, but such use or disclosure will be made in compliance with the law and limited to the requirements of the law.

AUTHORIZATION

Uses and/or disclosures, other than those described above, will be made only with your written Authorization, which you may revoke at any time.

APPOINTMENT REMINDER

The Practice may, from time to time, contact you to provide appointment reminders. The reminder may be in the form of a letter or postcard. The Practice will try to minimize the amount of information contained in the reminder. The Practice may also contact you by phone and, if you are not available, the Practice will leave a message for you.

TREATMENT ALTERNATIVES/BENEFITS

The Practice may, from time to time, contact you about treatment alternatives it offers, or other health benefits or services that may be of interest to you.

YOUR RIGHTS

You have the right to:

- Revoke any Authorization, in writing, at any time. To request a revocation, you must submit a written request to the Practice's Privacy Officer.
- Request restrictions on certain use and/or disclosure of your PHI as provided by law. However, the Practice is not obligated to agree to any requested restrictions. To request restrictions, you must submit a written request to the Practice's Privacy Officer. In your written request, you must inform the Practice of what information you want to limit, whether you want to limit the Practice's use or disclosure, or both, and to whom you want the limits to apply. If the Practice agrees to your request, the Practice will comply with your request unless the information is needed in order to provide you with emergency treatment.
- Receive confidential communications of PHI by alternative means or at alternative locations. You must make your request in writing to the Practice's Privacy Officer. The Practice will accommodate all reasonable requests.
- Inspect and copy your PHI as provided by law. To inspect and copy your PHI, you must submit a written request to the Practice's Privacy Officer. In certain situations that are defined by law, the Practice may deny your request, but you will have the right to have the denial reviewed. The Practice may charge you a fee for the cost of copying, mailing or other supplies associated with your request.

- Amend your PHI as provided by law. To request an amendment, you must submit a written request to the Practice's Privacy Officer. You must provide a reason that supports your request. The Practice may deny your request if it is not in writing, if you do not provide a reason in support of your request, if the information to be amended was not created by the Practice (unless the individual or entity that created the information is no longer available), if the information is not part of your PHI maintained by the Practice, if the information is not part of the information you would be permitted to inspect and copy, and/or if the information is accurate and complete. If you disagree with the Practice's denial, you have the right to submit a written statement of disagreement.
- Receive an accounting of non-routine disclosures of your PHI as provided by law. To request an accounting, you must submit a written request to the Practice's Privacy Officer. The request must state a time period which may not be longer than six years and may not include the dates before April 14, 2003. The request should indicate in what form you want the list (such as a paper or electronic copy). The first list you request within a 12 month period will be free, but the Practice may charge you for the cost of providing additional lists in that same 12 month period. The Practice will notify you of the costs involved and you can decide to withdraw or modify your request before any costs are incurred.
- Receive a paper copy of this Privacy Notice from the Practice upon request.
- To file a complaint with the Practice, please contact the Practice's Privacy Officer. All complaints must be in writing.
- If your complaint is not satisfactorily resolved, you may file a complaint with the Secretary of Health and Human Services, Office for Civil Rights. Our Privacy Officer will furnish you with the address upon request.
- To obtain more information, or have your questions about your rights answered, please contact the Practice's Privacy Officer.

PRACTICE'S REQUIREMENTS

The health care office:

- Is required by law to maintain the privacy of your PHI and to provide you with this Privacy Notice upon request.
 - Is required to abide by the terms of this Privacy Notice.
 - Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for all of your PHI that it maintains.
 - Will not retaliate against you for making a complaint.
 - Must make a good faith effort to obtain from you an acknowledgement of receipt of this Notice.
- Will post this Privacy Notice in its lobby and on the Practice's web site, if the Practice maintains a web site.