



SCHUCK FAMILY CHIROPRACTIC

76 East 15th Street
Edmond, Oklahoma 73013

Pediatric Intake Form (Birth to 12 Years)

Date: _____

Child's name: _____ DOB: _____

Gender: M / F

Parent/Guardian's Name: _____

Phone #: _____

Address: _____

City _____ State _____ Zip _____

Referred by: _____

Email address: _____

Has your child been checked by a Doctor of Chiropractic? Yes: ___ No: ___

If yes, please provide the name of the office and doctor.

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? Yes: _____ No: _____

Did you consume alcohol? Yes: _____ No : _____

Did you take medication? Yes: _____ No: _____

Reason for the medication:

Did you have any complications and when?

Birth History:



Did you have ultrasound during this pregnancy? Yes: _____ No: _____

What was the frequency? _____

Place of Birth: Home: _____ Birthing Center: _____ Hospital: _____

Provider: Midwife: _____ OB-Gyn: _____ other: _____

Type of Birth:

Vaginal: _____ C-Section: _____

Were pain Medications used?

Yes: _____ No: _____

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: birth ____/10 5-minutes ____/10 ____ Unsure

Did your child have a misshaped skull / head? Yes: _____ No: _____

Were there purple markings on their face? Yes: _____ No: _____

Did you breast feed your child? Yes: _____ No: _____

Does your child prefer one breast over the other? Yes: _____ No: _____

If yes, which side (circle one) Right Left

Did your child have any ties? Yes ____ No ____ if yes were they revised and where?

Does your child have any known food allergies? Yes: _____ No: _____

If yes, please list: _____

Health and developmental history



Has your child been immunized? Yes: _____ No: _____
Any known reactions to immunizations? Yes: _____ No: _____
Has your child ever had any surgeries? Yes: _____ No: _____

If yes, please elaborate. _____

Has your child been on antibiotics? Yes: _____ No: _____

If yes, how often and what for?

Is your child currently taking any medication? Yes: _____ No: _____

Is your child currently taking any vitamins? Yes: _____ No: _____

What concerns or issues is your child experiencing that you are seeking chiropractic care for?

How long have they been experiencing this?

Has anything made it better? If yes what? _____

Does anything make it worse? _____

Has your child experienced any major injuries? Yes No

If yes what: _____

Have you noticed any of the following symptoms?

Gastrointestinal

Constipation _____
Diarrhea _____
Colic _____
frequent spit up
or vomiting _____
discomfort during
Bowel movements _____
Bed wetting/potty
training regression _____

Respiratory

Asthma _____
persistent cough _____
Difficulty Breathing _____

Neurological

Tremors _____
seizures _____
headache _____
ADD/ADHD _____

Cardiovascular

Heart defects _____
Any issues when born? Yes No

Ear, Nose, Throat

Frequent nose bleeds _____
ear infections _____
hearing loss _____
sinus issues/allergies _____

Skin

Rash _____
Eczema _____
Dry skin _____

Has your child met all milestones on time?

0-3 mo:

able to smile/follow objects with eyes ____

can turn head side to side ____

rolls side to back ____

3-6 mo:

can lift head and chest on tummy _____

brings feet to mouth _____

can sit w/pelvic support _____

rolls back to tummy _____

6-12 mo:

rolls in both directions _____

(may) get into crawling position ____

can sit up by self ____

9-12 mo:

cross crawl begins ____

sitting to tummy/tummy to sit ____

can stand for a few seconds on own ____

(may) play in high bear position ____

12-19 mo:

starts to walk ____

enjoys social play ____

can move freely in all positions ____

more balance and coordination ____

Informed Consent to Treat:

I hereby authorize Dr. Schuck/Dr. Hanks/Dr. Freeman to administer exams and chiropractic care as deemed necessary to _____ (print minor patient's name).

Printed name of Parent/Guardian: _____

Date: _____

Signature parent/guardian: _____

Treating Doctor's signature: _____

ASSIGNMENT OF HEALTH BENEFITS

No. _____

The parties appearing below, on the ___ day of ___, 20___, hereby agree to the following conditions, covenants and terms regarding the assignment of health benefits appearing in Mr./Mrs./ Ms.

_____ policy issued by
_____.

I, _____ hereafter referred to as "Patient", understand and voluntarily agree to assign all applicable health provisions pertaining to payments or benefits appearing in my insurance policy with _____ in consideration for treatment rendered by Schuck Family Chiropractic. Hereafter referred to as "Doctor".

That Patient, the policy holder, requests, orders and directs _____
To pay Doctor directly to his/her office at 76 E. 15th Street Edmond, OK 73013 the sum due Doctor for treatment rendered.

The Doctor and Patient hereby entered into this assignment of benefits freely and voluntarily and evidenced by the signatures appearing below. That Patient and Doctor warrant that they have read this assignment of benefits and that each understand the legal effect of the same, and agree that each shall be bounded by the covenants, terms and conditions appearing herein.

Patient _____ Date _____

Doctor _____

Patient File # _____

Your Rights

You have the following rights regarding Health Information we have about you:

Right to Inspect and Copy. You have the right to inspect and copy Health Information that we may use to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this information, you must make your request in writing, to our Privacy Officer.

Right to Amend. If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing, to our Privacy Officer.

Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment, and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to our Privacy Officer.

Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operation. You also have a right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you can ask that we not share information about your particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to our Privacy Officer. **We are not required to agree with your request.** If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Right to Request Confidential Communication. You have the right to request that we communicate with you about your medical matters in a certain way or at a certain location. For example, you can ask that we contact you only by mail or at work. To request confidential communications, you must make your request, in writing, to our Privacy Officer. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You must ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice by contacting our office.

Changes to This Notice

We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a current copy of our notice at our office. The notice will contain the effective date on the first page, in the top right hand corner.

Complaints

If you believe your privacy has been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact our Privacy Officer. All complaints must be made in writing. **You will not be penalized for filing a complaint.**

By Subscribing my name below, I acknowledge receipt of a copy of this notice, and my understanding and my agreement to its terms.

_____ Patient Signature _____ Date