Cashin Chiropractic Healing and Wellness Center

Pediatric Intake Form

Name: _____ Nickname: _____ Current age: _____ Date of Birth: _____

Child's Home Address _____ City _____ State _____ Zip _____

Parent #1 _____ Phone (h) _____ (work) _____ (cell) _____

Parent #2 _____ Phone (h) _____ (work) _____ (cell) _____

Parent's Email _____

Child's Sex: Male O Female O Purpose of the appointment with doctor today: _____

Has child ever received chiropractic care? (Please circle) Yes O No O Referred by _____

If Child was adopted: ***Adoption Information***

Child's age when adopted _____ Date of Adoption _____

Known health history of child _____
(Use back of page for additional information as needed)

Pregnancy Information

Pregnancy History: _____
Pre-natal Supplements? Yes O No O Omega 3 Supplement? Yes O No O Pro-biotic Supplement? Yes O No O
Organic Diet? Yes O No O Any Prolonged Emotional Stress During Pregnancy? Yes O No O
Any Loss Suffered During Pregnancy? (Example: death, loss of job or pet) Yes O No O Comment: _____

Medications taken during pregnancy? _____
Any problems during pregnancy and/or labor? (Use back of page for additional information as needed)
_____

Delivery/Birth History: _____

Birth Information

Birth Weight: _____ Birth Length: _____ Epidural: Yes O No O
Type of Birth: Vaginal O Forceps O Breech O Cesarean O Home O Birthing Center O Hospital O
Apgar Scores: _____ Jaundice (yellow) at Birth? Yes O No O Cyanosis (blue) Yes O No O

Congenital Anomalies/Defects: _____

Infant Feeding: Breast O For how long? _____ Bottle O Which Formula? _____

Any issues with feeding? _____

Number of hours child sleeps daily: _____ Quality of Sleep: Good O Fair O Poor O

Has child had any vaccinations? _____

Number of Siblings: _____ Siblings Name, Age and Sex: _____

Date of last visit to any doctor: _____ Reason for that visit: _____

Has child ever been treated on an emergency basis? _____

At what age did child respond to sound: _____ Crawl: _____ Follow object with eyes: _____

Hold head up: _____ Stand: _____ Sit Alone: _____ Walk Alone: _____

Current Health Habits

Yes	No		Comments	*Notes by Doctor*
O	O	Diet (Eating healthy foods)?	_____	_____
O	O	Has child been in any accidents?	_____	_____
O	O	Exercise Regularly?	_____	_____
O	O	Hobbies/Sports injuries?	_____	_____

Sleeping Posture: O Side O Stomach O Back (Comment) _____

How are things going at school? (Comment) _____

Performance: O Good O Poor (Comment) _____

Interaction: O Good O Poor (Comment) _____

Does child have emotional stress? Family O School O Other _____

Any Present Complaints: _____

Pain or Problem started on _____Feels like: _____ Sharp Dull Ache Burns Numbness

Is condition interfering with school? _____ Sleep? _____ Routine? _____ Other? _____

Is this condition getting progressively worse? _____ Using any home remedies? _____

⇨ Please note **ANY** of the following signals that have presented, even if you feel they are unrelated:

<Under-Aroused>	*<Un-Stable>*	*<Over –Aroused>*
O Poor Attention	O Migraines	O Cold hands
O Impulsive	O Headaches	O Cold feet
O Easily Distracted	O Seizures	O Tight Muscles
O Disorganized	O Sleepwalking	O Teeth grinding
O Depressed	O Hot flashes	O Anxiety
O Lacking motivation		O Heart Palpitations
O Poor Concentration	O Food sensitivities	O Restless Sleep
O Spaciness	O Bed wetting	O Poor expression of emotions
O Constipation	O Eating Disorder	O poor immune system
O Low Pain Threshold	O Bipolar Disorder	O Racing Mind
O Difficulty waking up	O Mood Swings	O High Blood Pressure
O Worry	O Panic Attacks	O Accelerated Aging
O Irritable		O Irritable Bowel
O Low Energy		

<Exhausted>		
O Cancer	O Rheumatoid Arthritis	O Diabetes
O Depression	O Chronic Fatigue Syndrome	O Epstein-Barr Syndrome

O Eczema or Skin problems	O Pins & Needles in Legs or Arms	O Buzzing in Ears	O Vision Problems
O Low Blood Pressure	O Loss of Smell or Taste	O Dyslexia	O Loss of Memory
O Numbness in Fingers & Toes	O Diarrhea	O Dizziness or Fainting	O Sinus Problems
O Shortness of Breath	O Loss of Balance	O Face Flushed	O Bladder Problems
O Ear Infections	O Urinary Infections	O Speech Difficulty	O ADHD or ADD

Has child been under drug and medical care?_____

What medications does the child take?_____

How long has child been taking them?_____ Side effects noticed:_____

The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine my child for further evaluation:

_____ _____ _____

Signature (Parent or Guardian) Printed name of person completing this form *Date*

CHIROPRACTIC PC

HIPAA: PATIENT CONSENT

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

I hereby state that by signing this consent, I acknowledge and agree as follows:

1. I am aware that the full Cashin Chiropractic, P.C. Privacy Notice is available to me at any time upon request. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information (PHI) necessary for Cashin chiropractic, P.C. to provide treatment to me, and also necessary for Cashin Chiropractic, P.C. to obtain payment for that treatment and to carry out its health care operations. Cashin Chiropractic, P.C. explained to me that the Privacy Notice will be available to me in the future at my request. Cashin Chiropractic, P.C. 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. Cashin Chiropractic, P.C. 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 that might be used by Cashin Chiropractic, P.C.:

    a. Telephoning me at the number I provide and leaving a message on my answering machine or with the individual answering the phone
    b. Sending me a text on the mobile phone number that I provide
    c. Sending me an email at the email address I provide

4. Cashin Chiropractic, P.C. may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for Cashin Chiropractic, P.C. to treat me and obtain payment for that treatment, and as necessary for Cashin Chiropractic, P.C. to conduct its specific health care operations.

5. I understand that I have a right to request that Cashin Chiropractic, P.C. restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, Cashin Chiropractic, P.C. is requested restriction, and then the restriction is binding on Cashin Chiropractic, P.C.

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 Cashin Chiropractic, P.C. has already taken action in reliance on this consent.

7. I understand that if I revoke this consent at any time, Cashin Chiropractic, P.C. has the right to refuse to treat me.

Date: _____

Patient's (or Guardian's) Signature: _____

CHIROPRACTIC PC

OFFICE POLICY

AUTOMOBILE ACCIDENT INSURANCE

If you currently have Medical Payments Coverage (Med Pay) as a part of your car insurance, we will bill Med Pay for you. Please remember that you are personally responsible to pay your bill timely regardless of actions taken by your automobile insurer.

GENERAL

If you are unable to pay your account in full at the time services are rendered, you should be aware that the following rules apply to your account:

1. A finance charge of one and one half percent (1.5%) per month (18% A.P.R.) will be charge with a minimum of $5.00 on all accounts which are more than thirty (30) days old.
2. Sometimes it may become necessary to utilize a payment schedule (only on approval of the Doctor). If so, such a schedule must be strictly adhered to. In the event any payment is not made when due, the account will be turned over to a collection agency.
3. Should this office be required to turn your account over for collections, you will be required to pay all collection costs, attorneys' fees, and court costs.

CONSENT TO TREATMENT

A chiropractic manipulation or adjustment is a passive manual maneuver during which a three joint complex is suddenly carried beyond the normal range of motion without exceeding the boundaries of anatomical integrity. The usual characteristic is a thrust accompanied by an audible or cracking noise (Sandoz, 1976, 1981). Material risks inherent in the chiropractic adjustment include stroke, paralysis and even death. The risk of serious complication is one in 1,562,500 manipulations and the risk of death is one in 3,703,703 manipulations (Rand, 1995). As a matter of comparison, the risk of serious complication or death attributed to the use of non-steroid anti-inflammatory drugs is 100-400 times greater than for cervical manipulation in the treatment of similar conditions (JMPT, 1995).

AUTHORIZATION TO RELEASE INFORMATION & PAYMENT OF MEDICAL BENEFITS

By signing this form, you are hereby authorizing the release of any medical information necessary to process your insurance claims. You are also authorizing payment of medical benefits to CASHIN CHIROPRACTIC for services or products rendered. I certify that I have read and understand the above agreement/policy/explanation of the chiropractic adjustment(s) and related treatments and freely accept the terms. I further agree to abide by the terms/policies of CASHIN CHIROPPRACTIC as stated above to do whatever is necessary to effectuate them. By signing below, I have accepted the risk and consent to the treatment recommended.

Date: The _____ day of _____, 20 ____

Patient's (or Guardian's) Signature_____
Witness Signature _____