Family Chiropractic CLINIC

DR. JEFF HAND
DR. JENNIFER PERSON
DR. JOSH HOLBROOK
Doctors of Chiropractic

Youth Intake Form

Please allow our staff to photocopy your driver's license and insurance details.
Please note that this is confidential

Today's Date _____

Whom may we thank for referring you? _____

Has he/she ever been to chiropractic before □ Yes □ No When was his/her last visit? _____

_____

Last Name First Name Middle Name

_____

Address Date of Birth (MM/DD/YY)

_____

City State Zip Code Home Phone Cell Phone

Ethnicity: □ Hispanic □ non-Hispanic □ refuse **Language Spoken**: □ English □ Other_____

Race: □ White □ African American □Hispanic □ American Indian □ Asian □ More than one race □ refused

Parent # 1 Name_____**Phone** _____

Parent # 2 Name_____**Phone** _____

Parent Email Address(es) _____

Pediatrician and/or Family MD Name and Clinic Location_____

Insurance Carrier_____**Policy number**_____

Policy Carrier's First and Last Name _____

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NAME _____

What is the purpose of the appointment with the Chiropractor. Please note there must be a complaint relating to the spine (neck or back) if you are wanting insurance coverage for this visit. _____

_____

How did the symptoms start? _____

_____

When did the child first start noticing the current symptoms? _____

Intensity (how extreme are your current symptoms? (please circle one)

Absent 0 1 2 3 4 5 6 7 8 9 10 Agonizing

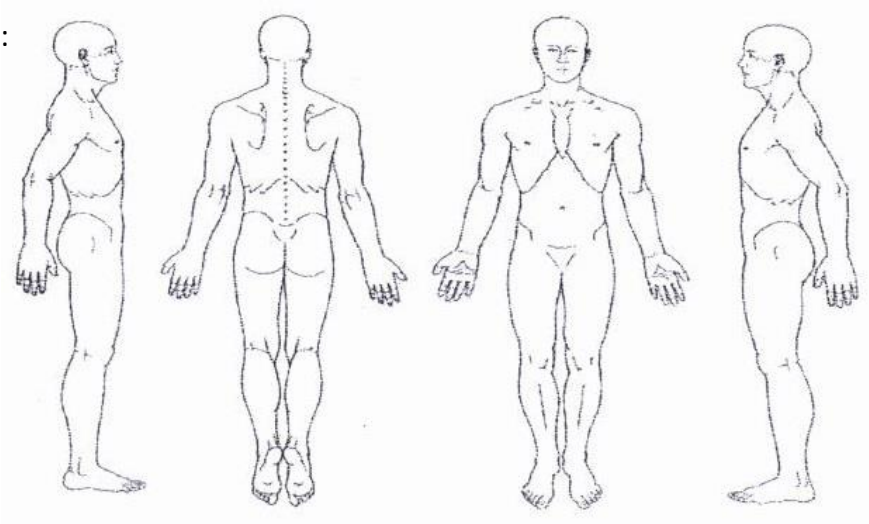
How often does the child feel the symptoms?

☐ Constant ☐ Comes and goes How Often? _____

Does the pain radiate shoot or travel and where?_____

Please show where the pain is:

□ Numbness
□ Tingling
□ Stiffness
□ Aching
□ Cramps
□ Nagging
□ Sharp
□ Burning
□ Shooting
□ Throbbing
□ Stabbing
□ Other



What makes the pain worse_____Better? _____

Previous treatments

□ Prescription medications	□ Surgery	□ Ice	□ Other _____
□ Over the counter medicine	□ Acupuncture	□ Heat	
□ Physical Therapy	□ Chiropractic	□ Massage	

What else should the doctor at Family Chiropractic know about the condition? _____

_____

Please list ALL current medications and supplements _____

_____

NAME _____

Family History

Relative	Previous/current major Illnesses (heart, cancer, diabetes)
Mother	_____
Father	_____
Sibling 1	_____
Sibling 2	_____

Are there any other hereditary health issues that you know about? _____

_____

Social history

Exercise	□ Daily	□ Weekly	□ How many times weekly_____
Pain reliever	□ Daily	□ Weekly	□ How much_____
Soft drinks	□ Daily	□ Weekly	□ How many daily_____
Water intake	□ Daily	□ Weekly	□ How much daily_____

Activities of Daily Living – How does the condition interfere with the child's life and ability to function?

	None	Mild	Moderate	Severe		None	Mild	Moderate	Severe
Sitting					Household chores				
Rising out of chair					Lifting objects				
Standing					Reaching overhead				
Walking					Showering/bathing				
Lying down					Dressing				
Bending over					Rolling in bed				
Climbing Stairs					Getting to sleep				
Using a computer					Staying asleep				
Getting in/out of a car					Concentrating				
Looking over shoulder					Exercising				

Previous surgical procedures and dates_____

_____

Previous Imaging and date

□ MRI _____ □ X-rays_____ □ CT Scan_____ □ Other_____

NAME _____

Has this child ever suffered from (please check any that apply):

- □ Allergies
- □ Anemia
- □ Arm Problems
- □ Arthritis
- □ Asthma
- □ Backaches
- □ Bed Wetting
- □ Behavioral Problems
- □ Blood Disorders
- □ Broken Bones
- □ Constipation/Diarrhea
- □ Colds/Flu
- □ Convulsions
- □ Diabetes
- □ Digestive Disorders
- □ Dizziness
- □ Chronic Earaches
- □ Fainting
- □ "Growing Pains"
- □ Headaches
- □ Heart Trouble
- □ Hyperactivity
- □ Hypertension
- □ Joint Problems
- □ Leg Problems
- □ Muscle Spasms
- □ Neck Problems
- □ Poor Appetite
- □ Paralysis Problem
- □ Rheumatic Fever
- □ Hernias
- □ Sinus Trouble
- □ Sleeping Problems
- □ Stomach Aches
- □ Walking Problems

Informed consent

I hereby consent to chiropractic adjustments and procedures: including various therapy modalities that are necessary with the adjustment by the chiropractic doctor or anyone working in this clinic authorized by the doctor. I will also have an opportunity to discuss with the doctor and/or with the office personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed. By any standard, I understand that chiropractic treatment is conservative and very safe. I also understand that, as in all health care, and in the practice of chiropractic, there are some very slight risks to treatment including but not limited to: muscle strain/sprain, rib fracture, disc injuries, and vertebral artery injury (i.e. stroke). I do not expect the doctor to be able to anticipate and explain all risks and complications. I wish to rely on the doctor to exercise judgment during the course of the procedure and future procedures, which the doctor feels at the time based on facts then known, is in my best interest. I consent to the chiropractic treatments offered or recommended to me by my chiropractor, including spinal adjustment. I intend this consent to apply to all of my present and future chiropractic care.

I understand and agree that health and accident insurance policies are an arrangement between and insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse co-issued remittances for the convenience of credit to my account; however, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable

□ **I have been offered and would *like* a copy of the Financial Information and Privacy policy of this clinic.**
□ **I have been offered and *decline* a copy of the Financial Information and Privacy policy of this clinic.**

_____

Child's full name (printed)

_____

Parent/Guardian Signature Date (MM/DD/YYYY)