McNeil Family CHIROPRACTIC

CHILDREN'S INTAKE FORM
(Ages Birth to 17 Years Old)

Welcome to our office…

DATE: _____

Child's Name: _____Nickname _____
FIRST MI LAST
Parent/Guardian Name: _____
FIRST MI LAST
Address: _____ City/State/Zip Code: _____
Home Phone: (___) _____ Work Phone: (___) _____ Cell Phone: (___) _____
Email address: _____
Date of Birth: _____/_____/_____ Age: _____ Gender: ☐ Male ☐ Female
Emergency Contact: _____ Phone: (___) _____ Relationship: _____
How did you hear of our office? ☐ Phone Book ☐ Website ☐ Friend/Family member ☐Other_____

Current Health Condition

What is your child being seen for? _____
Has your child seen any provider for this condition? ☐ No ☐ Yes (MD/Chiro/Physical Therapist/ Other_____)
If yes, what did they do, and did it help?_____
How long has the child been having this condition? _____
How do you believe the child's problem or pain began? _____
Are your child's symptoms related to an accident? ☐ No ☐ Yes Explain: _____
Is the condition: Getting better Getting worse Staying the same Constant Intermittent (on and off)
This condition interferes with: _____
If the condition is painful, what is the average pain rating? Mild Moderate Severe
Is there anything that you've done that helps the condition? _____
Is there anything that makes the condition worse? _____

BIRTH INFORMATION

Birth Date_____Gender_____Birth Weight_____Birth Length_____Current Age of Child_____
How many weeks gestation was your child born at? _____
Type of Birth: Vaginal____Forceps____Breech____Cesarean____Home____Birthing Center____Hospital____
Please list facility the child was born at and attending provider: _____
Apgar Score: *Normal / Abnormal* Jaundice (yellow) at Birth: *Yes / No* Cyanosis (blue) *Yes / No*
Congenital Anomalies/Defects_____
Infant Feeding: Breast_____Formula_____Other food or drink Information:_____
No. of Hours Child Sleeps Daily_____Quality of Sleep: Good_____Fair_____Poor_____ Naps? _____
Explain:_____
Number of Siblings_____Name(s) & Age(s) _____
Delivery/Birth History: _____
_____
Were there any problems during pregnancy and/or labor? _____
_____
Does the child suffer from colic, reflux or constipation? _____
How often does the child have a bowel movement? _____
Does the child frequently arch their neck/back or feel stiff? _____

CHILDHOOD DEVELOPMENT

Please list any abnormal delays:
Respond to Sound_____
Crawl_____
Follow an object with their eyes_____
Hold Head up_____
Stand_____
Sit Alone_____
Walk Alone_____

Any other concerns for childhood development: _____
_____
_____

HEALTH AND MEDICAL INFORMATION

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

☐ Diabetes	☐ Bed Wetting	☐ Convulsions	☐ Neck Problems
☐ Fainting	☐ Tuberculosis	☐ Backaches	☐ Heart Trouble
☐ Dizziness	☐ Stomach Aches	☐ Allergies	☐ Orthopedic Problems
☐ Asthma	☐ Walking Problems	☐ Rheumatic Fever	☐ Hypertension
☐ Sugar Concentration	☐ Headaches	☐ Blood Disorder	☐ Broken Bones
☐ Sleeping Problems	☐ Digestive Disorders	☐ Sinus Trouble	☐ Leg Problems
☐ Diarrhea	☐ Constipation	☐ Paralysis	☐ Joint Problems
☐ Arm Problems	☐ Hyperactivity	☐ Chronic Earaches	☐ Colds/Flu
☐ Arthritis	☐ Neuritis	☐ Anemia	☐ Poor Appetite
☐ Behavioral Problems	☐ Muscle Jerking	☐ Ruptures/Hernias	☐ "Growing Pains"

☐ Problems in school: _____
Additional Information: _____
Motor Vehicle Accidents: _____
Surgery Information: _____
Medications or Supplements: _____
Family Health History/Medical Conditions: _____
_____

SOCIAL INFORMATION

What time does your child go to bed? _____
Child's diet: ☐ Good ☐ Could be better ☐ Drinks a lot of soda, energy drinks, caffeine ☐ Drinks enough water ☐ Water intake could be better
Does your child need help with posture? Yes No
Is there use of electronics before bedtime? Yes No
Does your child get enough exercise? Yes No What do they do for exercise/activity?
_____
Any other social/health concerns? _____
Does the child wear a backpack on both shoulders? Yes No

----------Signatures & Authorizations----------

CONSENT FOR TREATMENT FOR TREATMENT OF A MINOR:

Any procedure intended to help, may also do harm. While chiropractic examinations and therapeutic procedures (e.g. spinal adjustment, ultrasound, electrical muscle stimulation, heat and cold application, and manual muscle therapy) are considered remarkably safe and effective, please understand that occasionally there may be some adverse reactions.

Although the chances for experiencing any of these complications are extremely small, it is the practice of this chiropractic office to fully inform and educate all of our patients. These complications include, but are not limited to: pain, swelling, discoloration, inflammation, disc Injury, sensory changes, bone fracture, nausea, soft tissue injury, stroke, dizziness, weakness and worsening of condition.

I voluntarily consent to the rendering of care, including treatment and performance of diagnostic procedures. I understand that I am under the care and supervision of the attending physician and it is the responsibility of the staff to carry out the instructions of such physician.
I understand that there is no guarantee or warranty for a specific cure or result. I understand that I can request further explanation regarding any and all possible risks attendant to my care.

Patient Name: _____

Parent Signature or Legal Guardian: _____ Date: _____

In the event that the legal guardians are unable to bring the child in, I authorize the following people to bring the child in for care:

_____	_____	_____	_____
Name	**Relationship**	**Name**	**Relationship**

--------Patient Financial Agreement--------

The undersigned patient understands that health and accident insurance policies are an arrangement between the insurance carrier and the insured patient. The patient understands that McNeil Family Chiropractic will prepare any necessary reports and forms to assist in receiving payment from the insurance company, and that any authorized payment will be paid directly to Dr. Amy Gunderson-McNeil/McNeil Family Chiropractic and will be credited to the proper account upon receipt. **However, if there is a problem where your insurance company refuses to pay for services rendered, you as the patient will be personally responsible for payment.**

- The undersigned patient agrees to allow McNeil Family Chiropractic to submit information needed to the insurance company for billing purposes.
- You as the patient agree to pay the charges in a timely manner (with-in 30 days), or on an agreed upon payment plan.
- The undersigned Patient requests, consents and agrees to any and all chiropractic treatment provided to the Patient from the Chiropractor.

Payment (Co-pays, deductibles, etc.) is due when services are rendered, unless other arrangements have been made in advance. The undersigned agrees to pay $30.00 for any returned checks.

Parent/Legal Guardian's Signature: _____ Date: _____

------No Show Policy------

Due to the high demand of our appointment times, and the fact that we often have a waiting list of people looking to get in, we cannot tolerate a missed appointment. We understand that circumstances may arise out of your control. We allow 2 missed appointments and then will refer you to another clinic to handle your care.
No showing for your first appointment will require you to leave your credit card information to reschedule. If you no show for the second time, we will charge your credit card our new patient cash rate.

I have read and understand the above statement.

Parent/Legal Guardian's Signature: _____ Date: _____