Chase Life CHIROPRACTIC

PEDIATRIC INTAKE FORM

Child's Name: _____
Birth Date: _____ /_____ /_____ Today's Date: _____ /_____ /_____ Age: _____
Birth Height: _____ Birth Weight: _____ Current Height: _____ Current Weight: _____ ▢ Male ▢ Female
Address: _____ City: _____ State: _____ Zip: _____
Mother's Name: _____ Mother's Phone #: _____ Date of Birth: _____ /_____ /_____
Father's Name: _____ Father's Phone #: _____ Date of Birth: _____ /_____ /_____
Pediatrician/Family MD: _____ City & State: _____
Last Visit Date: _____ /_____ /_____ Reason for Visit: _____
Who is responsible for bills/finances? _____ Relationship: _____
▢ Other (Please Explain) _____

PURPOSE OF THIS VISIT: ▢ Wellness Check-Up ▢ Injury or Accident ▢ Other: _____

WHAT ARE THE PRIMARY HEALTH CONCERNS FOR YOUR CHILD?_____
_____

1. When did this problem first begin? Date: _____/_____/_____ ▢ Unknown ▢ Gradual ▢ Sudden
2. Have you seen other doctors for these conditions? ▢ Yes ▢ No
    a. If yes, please name them and their specialty and date seen: yes, who & when?
    _____
    _____
    _____
3. What were the results? ▢ FAVORABLE ▢ UNFAVORABLE (please explain)
    _____
4. How is this problem **NOW**:
    ▢ Quickly Improving ▢ Slowly Improving ▢ Same ▢ Gradually Worsening ▢ On+Off
5. What makes things BETTER?_____ WORSE? _____
6. Any bowel or bladder problems since this problem began?: ▢ Yes ▢ No
    If yes; please describe:
    _____
    a. Ever experienced this problem before? ▢ Yes ▢ No
    b. If yes; when: _____ Days _____Weeks _____Months _____Years
7. Please list any medication, drugs, vitamins, herbs, other your child is taking: _____
    _____
8. Does your child participate in organized sports? ▢ Yes ▢ No
    a. If yes, have they ever sustained an injury? ▢ Yes ▢ No
    b. If yes, please explain:
    _____
    _____
9. Has your child ever been in an auto accident? ▢ Yes ▢ No
    a. If yes, Have they ever sustained an injury? ▢ Yes ▢ No
    b. If yes, please explain:
    _____
    _____
10. Are there any other health concerns, or is there anything else you'd like us to know about your child?
    _____

<u>WHAT ARE YOUR TOP THREE HEALTH GOALS FOR YOUR CHILD:</u>

1._____
2._____
3._____

PREGNANCY & FERTILITY HISTORY

Any Fertility Challenges? ▢ Yes ▢ No If yes, please explain _____
Did the mother smoke during pregnancy? ▢ Yes ▢ No If yes, how many per week? _____
Did the mother drink during pregnancy? ▢ Yes ▢ No If yes, how many per week? _____
Did the mother exercise during pregnancy? ▢ Yes ▢ No If yes, explain briefly_____
Was the mother ill during pregnancy? ▢ Yes ▢ No If yes, please explain_____
Any Ultrasounds taken during pregnancy? ▢ Yes ▢ No If yes, please explain_____
Please explain any notable episodes of emotional or physical stress during your pregnancy: _____
_____
_____
Please explain any other concerns or notable remarks about your child's conception or pregnancy:_____
_____
_____

LABOR & DELIVERY HISTORY

Child's birth was: ▢ Vaginal Birth ▢ Scheduled C-Section ▢ Emergency C-Section
How many weeks was your child born? _____
Child's birth was: ▢ at home ▢ at a hospital ▢ at a birthing center ▢ Other _____
Please check any applicable interventions or complications:
▢ Breech ▢ Induction ▢ Pain meds ▢ Manual Assistance ▢ Epidural ▢ Episiotomy
▢ Vacuum extraction ▢ Forceps ▢ Cord-wrapped ▢ None of the above

Please describe any other concerns or notable remarks about your child's labor and/or delivery? _____
_____
_____

GROWTH & DEVELOPMENT HISTORY

Is / was your child breastfed? ▢ Yes ▢ No If yes, how long? _____
Difficulty breastfeeding? ▢ Yes ▢ No If yes, is a certain side more difficult than other? _____
Did they ever use formula? ▢ Yes ▢ No If yes, at what age? _____
Did / does your child suffer from colic, reflux, skin issues or constipation as an infant? ▢ Yes ▢ No
If yes, please explain? _____
_____
Did / does your child frequently arch their neck / back, feel stiff or bang their head? ▢ Yes ▢ No
If yes, please explain? _____

POST BIRTH INFORMATION

Breast Fed: ▢ Yes ▢ No If yes, how long? _____ Introduced Solid Foods at _____ months
Food Allergies or Intolerances:
_____
Doses of antibiotics/prescription drugs your child has taken: Past 6 Months _____ Total of Lifetime _____
List all surgical operations and years:
_____
Has your Child ever been knocked unconscious? ▢ Yes ▢ No Fractured A Bone? ▢ Yes ▢ No
If yes to either of the above, please describe:
_____
Have you chosen to vaccinate your child? ▢ Yes, on schedule ▢ Yes, on delayed or selective schedule ▢ No
If yes, please list any vaccination reactions:_____
_____
Behavioral, social or emotional issues? ▢ Yes ▢ No If yes, please explain? _____
How many hours per day does your child typically spend watching a TV, computer, tablet or phone? _____
How would you describe your child's diet? ▢ whole, organic foods ▢ pretty average ▢ mainly processed foods

Please Mark "P" For In The Past OR Mark "C" For Currently Have:

____ Neck Problems	____ Headaches	____ Heart Trouble	____ Colic
____ Shoulder Pain	____ Migraines	____ Hypertension	____ Reflux
____ Arm Problems	____ Seizures/Convulsions	____ Asthma	____ Fall from Bed or Couch
____ Backaches	____ Fainting	____ Trouble Breathing	____ Fall from Changing Table
____ Hip Pain	____ ADD/ADHD	____ Rupture/Hernia	____ Fall from Crib
____ Leg Problems	____ Sensory & Spectrum	____ Poor Appetite	____ Fall from High Chair
____ Knee Pain	____ Projectile Vomiting	____ Stomach Aches	____ Fall in Baby Walker
____ Foot Pain	____ Sleep Problems	____ Digestive Disorders	____ Fall off Bicycle
____ Scoliosis	____ Recurrent Colds/Flu	____ Constipation	____ Fall off Monkey Bars
____ Broken Bones	____ Allergies	____ Diarrhea	____ Fall off Skateboard/Skates
____ Reflux/excessive spit up	____ Sinus Trouble	____ Bed Wetting	____ Fall off Slide
____ Muscle Pains	____ Dizziness	____ Torticollis	____ Fall Down Stairs
____ Orthopedic Problems	____ Chronic Earaches	____ Anemia	____ Fall off Swing
____ Poor Posture	____ Ear Infections	____ Growing Pains	____ Walking Trouble
____ Plagiocephaly	____ Communication Delays	____ Emotional Challenges	____ Anxiety
____ Motor Milestone Delays	____ Low energy/Fatigue	____ Sore throat / strep	____ Swollen tonsils/adenoids
____ Chronic Inflammation	____ Poor metabolism	____ Bronchitis	____ Blood Sugar Problems
____ Hormonal Challenges	____ Toe Walking	____ Gluten Intolerance	____ Kidney Challenges
____ Ulcerative Colitis	____ Crohn's Disease	____ Irritable Bowel Syndrome	____ Bloating

Other(s): _____ _____ _____

Activities Of Life

Please identify how the current condition is affecting the child's ability to carry out activities that are routinely part of life:

ACTIVITY:	EFFECT:			
Holding Head Up	▢ No Effect	▢ Painful (can do)	▢ Painful (limits)	▢ Unable to Perform
Tummy Time	▢ No Effect	▢ Painful (can do)	▢ Painful (limits)	▢ Unable to Perform
Nursing	▢ No Effect	▢ Painful (can do)	▢ Painful (limits)	▢ Unable to Perform
Sitting Up	▢ No Effect	▢ Painful (can do)	▢ Painful (limits)	▢ Unable to Perform
Crawling	▢ No Effect	▢ Painful (can do)	▢ Painful (limits)	▢ Unable to Perform
Standing Unassisted	▢ No Effect	▢ Painful (can do)	▢ Painful (limits)	▢ Unable to Perform
Walking Unassisted	▢ No Effect	▢ Painful (can do)	▢ Painful (limits)	▢ Unable to Perform
Sitting Up	▢ No Effect	▢ Painful (can do)	▢ Painful (limits)	▢ Unable to Perform
Climbing Stairs	▢ No Effect	▢ Painful (can do)	▢ Painful (limits)	▢ Unable to Perform
Household Chores	▢ No Effect	▢ Painful (can do)	▢ Painful (limits)	▢ Unable to Perform
Dressing	▢ No Effect	▢ Painful (can do)	▢ Painful (limits)	▢ Unable to Perform
Walking	▢ No Effect	▢ Painful (can do)	▢ Painful (limits)	▢ Unable to Perform
Running	▢ No Effect	▢ Painful (can do)	▢ Painful (limits)	▢ Unable to Perform
Sleep	▢ No Effect	▢ Painful (can do)	▢ Painful (limits)	▢ Unable to Perform
Pet Care	▢ No Effect	▢ Painful (can do)	▢ Painful (limits)	▢ Unable to Perform
Extended Computer Use	▢ No Effect	▢ Painful (can do)	▢ Painful (limits)	▢ Unable to Perform
Concentration	▢ No Effect	▢ Painful (can do)	▢ Painful (limits)	▢ Unable to Perform
Static Sitting	▢ No Effect	▢ Painful (can do)	▢ Painful (limits)	▢ Unable to Perform
Other:_____	▢ No Effect	▢ Painful (can do)	▢ Painful (limits)	▢ Unable to Perform

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that I have certain rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

1. Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations such as quality assessments and physician's certifications.

I acknowledge that I may request your NOTICE OF PRIVACY PRACTICES containing a more complete description of the uses and disclosures of my health information. I also understand that I may request, in writing, that you restrict how my private information is used to disclose to carry out treatment, payment, or healthcare operations. I also understand that you are not required to agree to my requested restrictions, but if you agree, then you are bound to abide by such restrictions.

_____ _____

GUARDIAN'S SIGNATURE DATE

INFORMED CONSENT FOR CHIROPRACTIC CARE

CHIROPRACTIC CARE, LIKE ALL FORMS OF HEALTH CARE, WHILE OFFERING CONSIDERABLE BENEFITS MAY ALSO PROVIDE SOME LEVEL OF RISK. THIS LEVEL OF RISK IS MOST OFTEN VERY MINIMAL, YET IN RARE CASES, INJURY HAS BEEN ASSOCIATED WITH CHIROPRACTIC CARE. THE TYPES OF COMPLICATIONS THAT HAVE BEEN REPORTED SECONDARY TO CHIROPRACTIC CARE INCLUDE: SPRAINS/STRAIN INJURIES, IRRITATION OF A DISC CONDITION, AND RARELY, FRACTURES. ONE OF THE RAREST COMPLICATIONS ASSOCIATED WITH CHIROPRACTIC CARE, OCCURING AT A RATE BETWEEN ONE INSTANCE PER ONE MILLION TO ONE PER TWO MILLION CERVICAL SPINE ADJUSTMENTS MAY BE A VERTEBRAL INJURY THAT COULD LEAD TO A STROKE.

PRIOR TO RECEIVING CHIROPRACTIC CARE IN THIS CHIROPRACTIC OFFICE, A HEALTH HISTORY AND PHYSICAL EXAMINATION WILL BE COMPLETED. THESE PROCEDURES ARE PERFORMED TO ASSESS YOUR SPECIFIC CONDITIONS, YOUR OVERALL HEALTH AND IN PARTICULAR, YOUR SPINAL HEALTH. THESE PROCEDURES WILL ASSIST US IN DETERMINING IF CHIROPRACTIC CARE IF NEEDED, OR IF ANY FURTHER EXAMINATIONS OR STUDIES ARE NEEDED. IN ADDITION THEY WILL HELP US DETERMINE IF THERE IS ANY REASON TO MODIFY YOUR CARE OR PROVIDE YOU WITH A REFERRAL TO ANOTHER HEALTH CARE PROVIDER. ALL RELEVANT FINDINGS WILL BE REPORTED TO YOU ALONG WITH A CARE PLAN PRIOR TO BEGINNING CARE.

I UNDERSTAND AND ACCEPT THAT THERE ARE RISKS ASSOCIATED WITH CHIROPRACTIC CARE AND GIVE CONSENT TO THE EXAMINATION THAT THE DOCTOR DEEMS NECESSARY AND CHIROPRACTIC CARE, INCLUDING SPINAL ADJUSTMENTS, AS REPORTED FOLLOWING MY ASSESSMENT.

_____ _____ _____

PRINT NAME OF PARENT/LEGAL GUARDIAN SIGNATURE DATE

WRITTEN CONSENT FOR A CHILD

NAME OF PRACTICE MEMBER WHO IS A MINOR/CHILD _____

I UNDERSTAND THAT I AM DIRECTLY AND FULLY RESPONSIBLE TO CHASE LIFE CHIROPRACTIC FOR ALL FEES ASSOCIATED WITH CHIROPRACTIC CARE MY CHILD RECEIVES. I AUTHORIZE DR. CHASE BLAHA AND ANY AND ALL CHASE LIFE CHIROPRACTIC STAFF TO PERFORM DIAGNOSTIC PROCEDURES, RADIOGRAPHIC EVALUATIONS, RENDER CHIROPRACTIC CARE AND PERFORM CHIROPRACTIC ADJUSTMENTS TO MY MINOR/CHILD. ALL RISKS OF CHIROPRACTIC CARE HAVE BEEN EXPLAINED TO ME I HAVE CONVEYED MY UNDERSTANDING OF THESE RISKS TO THE DOCTOR.
AS OF THIS DATE, I HAVE THE LEGAL RIGHT TO SELECT AND AUTHORIZE HEALTH CARE SERVICES FOR MY MINOR/CHILD. IF MY AUTHORITY TO SELECT AND AUTHORIZE CARE IS REVOKED OR ALTERED, I WILL IMMEDIATELY NOTIFY CHASE LIFE CHIROPRACTIC. UNDER THE TERMS AND CONDITIONS OF MY DIVORCE, SEPARATION, OR OTHER LEGAL AUTHORIZATION, THE CONSENT OF A SPOUSE/FORMER SPOUSE OR OTHER GUARDIAN IS NOT REQUIRED. IF MY AUTHORITY TO SO SELECT AND AUTHORIZE THIS CARE SHOULD CHANGE IN ANY WAY, I WILL IMMEDIATELY NOTIFY CHASE LIFE CHIROPRACTIC.

_____ _____

PRINT NAME OF GUARDIAN RELATIONSHIP

_____ _____

GUARDIAN SIGNATURE DATE

_____ _____

DOCTOR/CA SIGNATURE DATE

PRACTICE MEMBER INFORMATION
(Must be completed before services can be rendered)

NAME: _____
FIRST MIDDLE LAST
SOCIAL SECURITY NUMBER: _____

CONTACT IN CASE OF EMERGENCY: _____ PHONE:_____

NAME OF PRIMARY INSURANCE CARRIER: _____

NAME OF INSURED: _____ INSURED DATE OF BIRTH: _____

INSURED SOCIAL SECURITY NUMBER: _____

NAME OF SECONDARY INSURANCE CARRIER: _____

NAME OF INSURED: _____ INSURED DATE OF BIRTH: _____

INSURED SOCIAL SECURITY NUMBER: _____

INSURANCE POLICIES AND FEE SCHEDULE

- CONSULTATION: INCLUDES PRACTICE MEMBER HISTORY. THIS SERVICE IS COMPLIMENTARY
- ASSESSMENT (NEW OR ESTABLISHED PRACTICE MEMBER): INCLUDES ONE OR MORE OF THE FOLLOWING: THERMOGRAPHY, SURFACE ELECTROMYOGRAPHY, RANGE OF MOTION, MOTION AND/OR STATIC PALPATION, LEG CHECK $50-$75
- CHIROPRACTIC ADJUSTMENT: THE ACTUAL RE-ALIGNMENT OF THE VERTEBRA DONE BY HAND. OFTEN A SOUND WILL BE HEARD BUT IF THERE IS NO AUDITORY RESULT, IT DOES NOT MEAN THE ADJUSTMENT HAS NOT TAKEN PLACE. $40-$60
- XRAYS: SPECIFIC XRAY VIEWS TAKEN OF YOUR SPINE TO BE DETERMINE A MISALIGNMENT/SUBLUXATION OF YOUR VERTEBRAE. THESE CAN ALSO BE USED TO INDICATE PROGRESS AFTER PERIOD OF CARE. $50 PER VIEW

RELEASE OF AUTHORIZATION/ASSIGNMENT OF BENEFITS

I AUTHORIZE AND REQUEST PAYMENT OF INSURANCE BENEFITS DIRECTLY TO CHASE BLAHA, DC. I AGREE THAT THIS AUTHORIZATION WILL COVER ALL SERVICES RENDERED UNTIL I REVOKE THE AUTHORIZATION. I AGREE THAT A PHOTOCOPY OF THIS FORM MAY BE USED IN PLACE OF THE ORIGINAL. I UNDERSTAND THAT ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT AND THAT IT IS CUSTOMARY TO PAY FOR SERVICES WHEN RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR CHARGES NOT COVERED BY THIS ASSIGNMENT AND THAT CHASE LIFE CHIROPRACTIC RESERVES THE RIGHT TO ADD A $25.00 SERVICE CHARGE TO MY ACCOUNT FOR ANY RETURNED CHECK OR CHARGEBACK. I AUTHORIZE THE FACILITY ALONG WITH ANY BILLING SERVICE AND THEIR COLLECTION AGENCY OR ATTORNEY WHO MAY WORK ON THEIR BEHALF, TO CONTACT ME ON MY CELL PHONE AND/OR HOME PHONE USING PRE-RECORDED MESSAGES, ARTIFICIAL VOICE MESSAGES, AUTOMATIC TELEPHONE DIALING DEVICES OR OTHER COMPUTER ASSISTED TECHNOLOGY, OR BY ELECTRONIC MAIL, TEXT MESSAGING OR ANY OTHER FORM OF ELECTRONIC COMMUNICATION.

SIGNED: _____ DATE: _____

MEDIA RELEASE AGREEMENT

I grant permission to Chase Life Chiropractic hereinafter known as the “Media” to use my child’s image (photographs and/or videos) for use in Media publications including: Social Media Posts, Videos, Email Blasts, Education Brochures, Newsletters, Handouts, Magazines, General Publications, Website and/or Affiliates.

I hereby waive any right to approve the finished photographs or electronic matter that may be used in conjunction with them now or in the future, whether that use in known to me or unknown, and I waive any right to royalties or other compensation arising from or related to the use of the image(s).

Please initial the paragraph below:
_____ I am the parent or guardian of the below named child. I have read this release before signing below, and I fully understand the contents, meaning and impact of this release. I understand that I am free to address any specific questions regarding this release by submitting those questions in writing prior to signing, and I agree that my failure to do so will be interpreted as a free and knowledgeable acceptance of the terms of this release.

_____ _____
PRINT NAME (your name or minor child name DATE

_____ _____
SIGNATURE SIGNATURE OF LEGAL GUARDIAN (if under 18 years of age)

X-RAY AUTHORIZATION

Last, First, M: _____
FILE #: _____
DOB: _____

AS YOUR HEALTHCARE PROVIDER, WE ARE LEGALLY RESPONSIBLE FOR YOUR CHIROPRACTIC RECORDS.
WE MUST MAINTAIN A RECORD OF YOUR X-RAYS IN OUR FILES.
AT YOUR REQUEST, WE WILL PROVIDE YOU WITH A COPY OF YOUR X-RAYS IN OUR FILES.
THE FEE FOR COPYING YOUR X-RAYS ON A DISC IS $15.00. THIS FEE MUST BE PAID IN ADVANCE.
DIGITAL X-RAYS ON CD WILL BE AVAILABLE WITHIN 72 HOURS OF PREPAYMENT ON ANY REGULAR DAY OF OPERATION.
PLEASE NOTE: X-RAYS ARE UTILIZED IN THIS OFFICE TO HELP LOCATE AND ANALYZE VERTEBRAL SUBLUXATIONS.
THESE X-RAYS ARE NOT USED TO INVESTIGATE FOR MEDICAL PATHOLOGY. THE DOCTOR OF CHASE LIFE CHIROPRACTIC DOES NOT DIAGNOSE OR TREAT MEDICAL CONDITIONS; HOWEVER, IF ANY ABNORMALITIES ARE FOUND, WE WILL BRING IT TO YOUR ATTENTION SO YOU CAN SEEK PROPER MEDICAL ADVICE.
BY SIGNING BELOW YOU ARE AGREEING TO THE ABOVE TERMS AND CONDITIONS.

_____ _____
PRINT NAME HERE DATE OF BIRTH

_____ _____
SIGNATURE DATE

FEMALE PATIENT ONLY: TO THE BEST OF MY KNOWLEDGE, I BELIEVE I AM NOT PREGNANT AT THE TIME THE X-RAYS ARE TAKEN AT CHASE LIFE CHIROPRACTIC.

_____ _____
SIGNATURE DATE

---------- *DO NOT WRITE BELOW THIS LINE* ----------

☐ Lat Cervical ☐ Flex/Ext

CM	Kvp	Time	MAS
☐10-11	☐78	☐1/24	12.5
☐12-13	☐	☐1/20	15
☐14-15		☐1/15	20
☐16-17		☐1/10	30
		☐2/15	40

MA 300 Size 8x10

☐ Lower Cervical

CM	Kvp	Time	MAS
☐14-15	☐70	☐1/10	20
☐16-17	☐	☐2/15	30
☐18-19		☐3/20	40
☐20-21		☐2/10	50
☐22-23			

MA 300 Size 8x10

☐ APOM

CM	Kvp	Time	MAS
☐14-15	☐70	☐1/10	20
☐16-17	☐	☐2/15	30
☐18-19		☐3/20	40
☐20-21		☐2/10	50
☐22-23			

MA 300 Size 8x10

Other
View _____

CM_____ Kvp _____

MAS_____ MA_____

Size _____

Sex: M / F

NOTES:
_____
_____
_____
_____

☐ Lateral Thoracic

CM	Kvp	Time	MAS
☐22-23	☐80	☐1/15	20
☐24-25	☐	☐1/10	30
☐26-27		☐2/15	40
☐28-29		☐2/10	50
☐30-31		☐1/4	75
☐32-33		☐3/10	90
☐34-35		☐2/5	120
☐36-37		☐1/2	150

MHA 300 Size14x17

☐ Lateral Lumbar

CM	Kvp	Time	MAS
☐26-27	☐88	☐2/10	30
☐28-29	☐90	☐1/4	40
☐30-31	☐92	☐3/10	50
☐32-33	☐94	☐2/5	70
☐34-35	☐96	☐1/2	90
☐36-37	☐	☐3/5	120
☐38-39		☐4/5	160
☐40-41		☐1	200
☐42-43		☐1 1/2	
		☐2	

MA 200 Size 14x17

CA Initials:
_____

☐ A-P Thoracic

CM	Kvp	Time	MAS
☐16-17	☐75	☐1/20	17
☐18-19	☐	☐1/15	22
☐20-21		☐1/10	30
☐22-23		☐2/15	40
☐24-25		☐2/10	50
☐26-27		☐1/4	75
☐28-29		☐3/10	90
☐30-31		☐2/5	120

MA 300 Size14x17

☐ A-P Lumbar

CM	Kvp	Time	MAS
☐20-21	☐76	☐1/15	40
☐22-23	☐78	☐1/10	50
☐24-25	☐80	☐2/15	75
☐26-27	☐	☐2/10	90
☐28-29		☐1/4	120
☐30-31		☐3/10	150
☐32-33		☐2/5	120
☐34-35		☐1/2	170
☐36-37		☐3/5	210
☐38-39		☐4/5	
☐40-41		☐1	
☐42-43		☐1 1/2	
		☐2	

MA 300 Size 14x17