Chiropractic Family Wellness Center
1747 Smizer Station Rd, Ste 4, Fenton, MO 63026
Phone: 636-825-6555 Fax: 636-825-6546
Dr. Emily Odom – Dr. Katie Etnier

Pediatric Chiropractic Intake Form (4 & under)

Patient Name: _____ Today's Date___/___/___

Birth Date: ___/___/___ Age: _____ Gender: ☐ Male ☐ Female

Street Address: _____

City: _____ State: _____ Zip Code: _____

Mother's Phone: (___)_____ Father's Phone: (___)_____

Would you like to receive Text Message Reminders for future appointments? ☐ Yes ☐ No

Which parent would like to receive the reminder? ☐ Mother ☐ Father

Child's Height: _____ Child's Weight: _____

Pediatrician/Family MD: _____ Phone: (___)_____

Has your child been adjusted by a chiropractor before: ☐ Yes ☐ No

Previous Chiropractor's Name: _____

Pregnancy History

Third Trimester Presentation: ☐ Vertex ☐ Breech ☐ Transverse ☐ Face/Brow

Type of Birth: ☐ Vaginal ☐ Forceps ☐ Cesarean ☐ Suction Cap or Vacuum

Location: ☐ Home ☐ Hospital ☐ Birthing Center ☐ Other: _____

Were there complications during pregnancy? ☐ Yes ☐ No Explain: _____

Were there any complications during delivery? ☐ Yes ☐ No Explain: _____

Was there presence of: ☐ Jaundice (Yellow)? ☐ Cyanosis (Blue)? ☐ Congenital Anomalies/Defects?

If yes, please explain: _____

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Infant History

Feeding: ☐ Breast: ___# of Months ☐ Bottle: ___# of Months ☐ Formula: ____# of Months

Brand(s): _____

Number of hours of sleep per night: _____ Quality of Sleep: ☐ Good ☐ Fair ☐ Poor

Has your child received vaccinations? ☐ Yes ☐ No

☐ Suggested Schedule ☐ Alternative Schedule

Developmental/Health History

Childhood Diseases: (Check all that apply)

☐ Chicken Pox ☐ Mumps ☐ Measles ☐ Rubella ☐ Whooping Cough ☐ Other: _____

According to the National Safety Council, approximately 50% of children fall head first from a high place during their first year of life (i.e) a bed, changing table, down stairs, etc.

Was this the case with your child? ☐ Yes ☐ No Explain: _____

Please check any of the following conditions that your child has now or has in the past. While they may seem unrelated to the purpose of the appointment, they can affect the overall diagnosis and care plan.

☐	Colic	☐	Digestive Problems	☐	Scoliosis	☐	Recurring Fevers
☐	Ear Infections	☐	Seizures	☐	Headaches/Migraines	☐	Respiratory Tract Infections
☐	Frequent Colds/Croup	☐	Hyperactivity/ADD/ADHD	☐	Back Pain	☐	Frequent Crying Spells
☐	Asthma	☐	Autism/PPD	☐	Neck Pain	☐	Asymmetrical Crawling or Gait
☐	Allergies	☐	Temper Tantrums	☐	Head Tilt	☐	Tip Toe Walking
☐	Sinus Problems	☐	Sleeping Problems	☐	Growing Pains	☐	Red, Swollen, Painful Joint
☐	Strep Throat	☐	Night Terrors	☐	Hearing Problems	☐	Slow or Absent Reflexes
☐	Acid Reflux	☐	Anxiety	☐	Dizziness	☐	Regression of Milestones
☐	Bed Wetting	☐	Depression	☐	Low Energy	☐	Failure to Thrive/Slow Weight Gain
☐	Constipation	☐	Eczema/Rashes	☐	Poor Nutrition	☐	Limited Exercise
☐	Other Health Problems:						

Family Medical History:_____

_____

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Reason for the Visit

Describe the purpose for this visit: _____

When & How did this challenge begin: _____

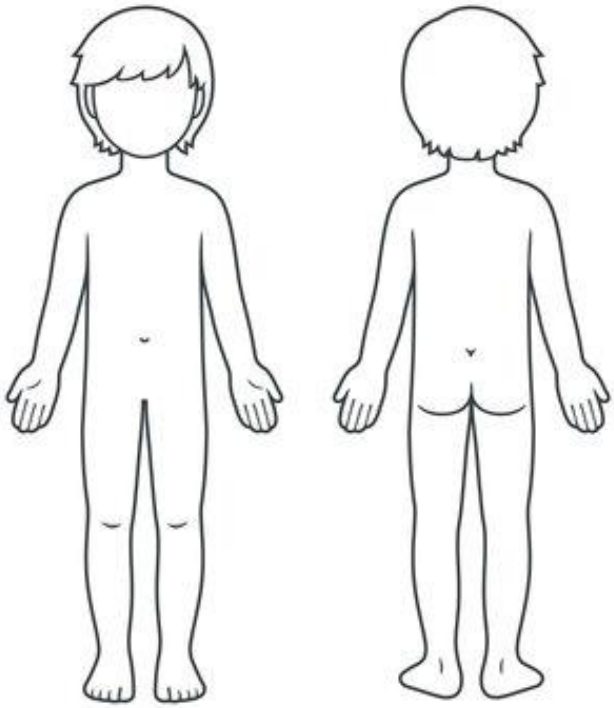
Since the problem began it is: ☐ Getting Better ☐ Getting Worse ☐ About the Same

What is the pattern of this problem? ☐ Constant ☐ Intermittent ☐ Occasional ☐ Cyclic

Have you seen other professionals for this condition? ☐ Yes ☐ No

Name of professional: _____

Use the diagram to indication with an **X** where you or your child notices discomfort or problems occurring:



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Authorization for Care of a Minor

I hereby grant permission to Chiropractic Family Wellness Center to perform chiropractic examinations and therapeutic procedures including but not limited to spinal adjustments, ultrasound, heat/ice application, electrotherapy, and manual muscle therapy that are considered safe and effective methods of care.

I understand that any procedure intended to help may have complications. While the chances of experiencing complications are small it is the practice of this clinic to inform out patients about them. These complications include, but not limited to, soreness, inflammation, soft tissue injury, dizziness, burns, and temporary worsening of symptoms. More serious complications are extremely rare. Additional information on side-effects and complications is available upon request.

I have read and understand the above statements regarding treatment side effects. I also understand that there is no guarantee or warranty for specific cure or result.

Minor's Printed Name: _____

Minor's Date of Birth: _____/_____/_____

Printed name of Parent/Guardian: _____

Signature of Parent/Guardian: _____

Today's Date: _____/_____/_____

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Patient Acknowledgement and Receipt of Notice Privacy Practices Pursuant to HIPAA and Consent for Use of Health Information

Patient Name: _____ **Patient DOB:** _____/_____/_____

The Undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant to HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request.

In order for our office to provide **ANY** information to your spouse, parent, relative, or other designates, we must have permission. (This would include appointments schedules, X-rays, receipts, insurance information, health records and any other information that pertains to your treatment.) You may indicate your permission by listing names here:

May information may be shared with: (List Names & relationship to patient)

Please indicate the name and contact information of your primary care physician for the purpose of care coordination with the chiropractic physician:

Primary Care Doctor Name: _____

Address/Phone: _____

The undersigned does hereby consent to the use of his/her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA Compliance Manual, State Law and Federal Law.

If patient is a minor or under a guardianship order as defined by State law.

Parent/Guardian Signature: _____ **Today's Date:** ____/____/_____

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Informed Consent to Chiropractic Treatment

I herby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including various modes of physical therapy, and if necessary, electric muscle stimulation, or spinal traction on me (or on the patient named below, for whom I am legally responsible for:_____) by the chiropractic physician and/or anyone working in this office authorized by the chiropractic physician.

I further understand that such chiropractic service may be performed by the Physician of Chiropractic named: **Dr. Brittany Warren/Dr. Emily Odom/Dr. Katie Etnier**, and/or other Physicians of Chiropractic who may treat me now or in the future at this office. I have had an opportunity to discuss with the Doctor of Chiropractic Family Wellness Center and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine and all health care, the practice of chiropractic carries some risks to treatment, including but not limited to: fractures, disc injuries, strokes (CVA), dislocations, and sprains. I do not expect the physician to be able to anticipate and explain all risks and complications. Further, I wish to rely on the physician to exercise judgment during the course of the procedures which the physician feels are in the best interest at the time, based upon the facts then known.

I have read, or have had read to, the above consent. I have also had an opportunity to ask questions about its contents, and by signing below, I agree to the treatment recommended by my physician. I intend this consent form to cover the entire course of treatment for my present condition(s) and for any condition(s) for which I seek treatment at this facility.

To be completed by the patient:

Print Patient's Name: _____ Today's Date: _____/_____/_____

Signature of Patient: _____

To be completed by the patient's representative, if necessary, (eg: if the patient is minor or is physically or mentally incapacitated):

Print Name of Patient: _____

Print Name of Representative: _____

Signature of Representative:_____ Today's Date: _____/_____/_____

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Payment Policy

Due to the increasing high deductible health plans, we are now asking all patients to store a credit card on file with us. Your card will not be charged until after we submit your claims to your health plans. You will only be responsible for any amount that your health plan indicates that you owe. We will not charge your card if you do not owe anything.

Note:
When your credit card information is entered, it is encrypted and cannot be viewed or accessed by our organization. Your system is registered with Visa and MasterCard and independently certified as a PCI-DSS Level One Service Provider.

Authorization:
Until further notice, I authorize CHIROPRACTIC FAMILY WELLNESS CENTER to charge the patient responsible balance on my account to the following credit card.
Choose One: □ **Visa** □ **Mastercard** □ **Discover** □**Use Card on File**

Last Four Digits of Credit Card Number: _____
Expiration Date (mm/yy): _____

I understand that once the health plan has paid their portion of my care that I will receive an explanation of benefits (EOB). The health plan EOB will state any balance remaining to be paid by me. I agree that CHIROPRACTIC FAMILY WELLNESS CENTER may charge my credit card the balance due when they receive a copy of the EOB. I also understand that CHIROPRACTIC FAMILY WELLNESS CENTER may charge my credit card at time of visit for any copays and/or open balance due as well, if they determine that a prior balance exists.

I understand that if, after payments by credit card, I later dispute the charges, unless prohibited by law, I agree not to cancel, revoke, chargeback or dispute any previously entered charge on my credit card. If I do so, and it is later determined that the charge was properly authorized, I agree to pay all out of pocket fees and costs incurred by the CHIROPRACTIC FAMILY WELLNESS CENTER as a result of improper cancellation, revocation, chargeback or dispute.

I understand that I may cancel this authorization at any time by contacting CHIROPRACTIC FAMILY WELLNESS CENTER. This authorization will remain in effect until canceled.

Please notify me 7 days in advance of charging my card on file by:

□ Email at the following email address _____

□ Phone call at the following phone number _____

_____ Date Signed _____
Patient Signature

_____
Printed Name

_____
Patient Name (if different than above)