

HEALING HANDS CHIROPRACTIC, LLC

3 Hall Ave ♦ Wallingford, CT 06492 ♦ 203-626-9994 ♦ healinghandsdc.com

Child Intake Form

PERSONAL INFORMATION

Child's Name: _____

Gender M F Age _____ Birthdate _____

Child's SS# _____

Mother's Name _____

Phone (H) _____ (W) _____

Employer _____

May we send you our office newsletters? Yes No

Date _____

Address _____

City _____ State _____ Zip _____

Home # _____ Mobile # _____

Father's Name _____

Phone (H) _____ (W) _____

Employer _____

Whom may we thank for referring you? _____

BIRTH INFORMATION

We believe that it is never too early to get involved in maintaining optimal health. Problems with the spine and nervous system can begin with the birth process or very early in life, so it is important to have our nervous systems checked regularly.

What was your child's birth like? _____

How long was the entire labor? _____ How long did the mother actually push? _____

Has this child been immunized? Yes No If yes, when and for what? _____

Did mom have any health concerns during pregnancy? _____

Child's birth weight _____ Did this child go full term? Yes No Delivery: Vaginal ___ C-Section ___

Was labor induced: Yes No Was this child breast fed? Yes No How long? _____

HEALTH HISTORY

Please mark "Yes" or "No" to indicate if your child has had any of the following:

Sugery:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ear infections:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pneumonia:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Sore Throat:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Seizures:	<input type="checkbox"/> Yes <input type="checkbox"/> No
HIV/AIDS	<input type="checkbox"/> Yes <input type="checkbox"/> No	ADD/ADHD	<input type="checkbox"/> Yes <input type="checkbox"/> No	Measles:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Mumps:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Asthma:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Chicken Pox:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Allergies:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Bed wetting:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Croup:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Conditions:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Digestive Problems:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Lung Problems:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Kidney Problems:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Emotional Problems:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cancer:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Back Pain:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Headaches:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other:	<input type="checkbox"/> Yes <input type="checkbox"/> No

What other wellness professionals are currently part of your health care team?

Massage Therapist Acupuncturist Naturopath Homeopath Other _____

How many Medical Doctor's office visits did your child have last year?

None Less than 2 Between 2 and 5 More than 5

Has this child had previous Chiropractic care? Yes No This year? Yes No

If yes, with whom _____

List previous surgeries and dates: _____

Medications: Pain Meds Heart Meds Cholesterol Meds Birth Control Other _____

There many different types of stresses that can have serious consequences regarding your child's future health. Please indicate whether they have ever experienced stress in any of the following areas. Your answers will enable us to determine which factors have contributed to their present health concerns.

- | | | | |
|------------------------------------|--|---------------------------------------|--|
| Repeated/prolonged Antibiotic Use: | <input type="checkbox"/> Yes <input type="checkbox"/> No | Inhaler Use: | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Car Accident(s): | <input type="checkbox"/> Yes <input type="checkbox"/> No | Prescription Medication: | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Fall/Jump from a height <3 feet: | <input type="checkbox"/> Yes <input type="checkbox"/> No | Surgery: | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Fall/Jump from a height >3 feet: | <input type="checkbox"/> Yes <input type="checkbox"/> No | Vaccinations: | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Childhood Illness: | <input type="checkbox"/> Yes <input type="checkbox"/> No | Youth Sports: | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Head Trauma: | <input type="checkbox"/> Yes <input type="checkbox"/> No | Other Trauma (physical or emotional): | _____ |

47% of all children fall on their head by the age of one and have at least 200 major falls by the age of 5 years old. Please answer these questions regarding your child's health.

- When was your child's most recent fall? _____
- Was any care given? Yes No Was s/he checked by a chiropractor? Yes No
- If this child has been involved in a motor vehicle accident as a passenger Briefly describe: _____
- Was any care given? Yes No Was s/he checked by a chiropractor? Yes No
- What sports or recreational activities does s/he do? _____
- Describe your child's most recent stress, strain, or injury while doing these activities? _____
- Was any care given? Yes No Was s/he checked by a chiropractor? Yes No

FAMILY HEALTH HISTORY

Has any member of your family ever had:

- | | | | | | | | |
|----------------|---|---|------------|-----------------|---|---|------------|
| Diabetes? | Y | N | Who? _____ | Cancer? | Y | N | Who? _____ |
| Heart Disease? | Y | N | Who? _____ | Allergies? | Y | N | Who? _____ |
| Scoliosis? | Y | N | Who? _____ | Spinal Surgery? | Y | N | Who? _____ |
| Other? | Y | N | Who? _____ | | | | |

CURRENT HEALTH CONCERNS

What is the nature of your visit today: Chiropractic wellness evaluation/no specific concern Specific health concern

If specific concern, please continue with this section. Describe concern: _____

List other providers seen for this condition: _____

Treatments or recommendations given to date: _____

INSURANCE (if applicable)

- Primary:** Who is responsible for this account? _____ Relationship: self spouse parent other _____
- Insurance Co. _____ Group # _____ Subscriber's Name _____
- Subscriber's Birthdate _____ SS# _____ - _____ - _____
- Additional Insurance** Yes No Insurance Co. _____ Group # _____
- Subscriber's Name _____ Subscriber's Birthdate _____ SS# _____ - _____ - _____
- Relationship: self spouse parent other _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Dr. Tracy Malton all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature

Relationship

Date

Healing Hands Chiropractic LLC
HIPAA COMPLIANCE SIGNATURE PAGE

Patient Name _____

Person/s you are **releasing** information to: _____

****Please choose one*** _____ Any information _____ Billing information only

Person/s **not to release** information to: _____

Patient signature

OR

Guardian signature _____

Print Name if Guardian _____ Date _____

A copy of complete HIPPA policy is available by request.

_____ Refused to sign _____
