HEALING HANDS CHIROPRACTIC, LLC

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

Child Intake Form

PERSONAL INFORMATION

Date_____

Child's Name:_____ Address_____

Gender ❑ M ❑ F Age_____ Birthdate_____

_____
City State Zip

Child's SS#_____ Home #_____ Mobile #_____

Mother's Name _____ Father's Name _____

Phone (H)_____ (W)_____ Phone (H)_____ (W)_____

Employer _____ Employer _____

May we send you our office newsletters? ❑ Yes ❑ No 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:	❑ Yes ❑ No	Ear infections:	❑ Yes ❑ No	Pneumonia:	❑ Yes ❑ No
Sore Throat:	❑ Yes ❑ No	Hepatitis:	❑ Yes ❑ No	Seizures:	❑ Yes ❑ No
HIV/AIDS	❑ Yes ❑ No	ADD/ADHD	❑ Yes ❑ No	Measles:	❑ Yes ❑ No
Mumps:	❑ Yes ❑ No	Asthma:	❑ Yes ❑ No	Chicken Pox:	❑ Yes ❑ No
Allergies:	❑ Yes ❑ No	Bed wetting:	❑ Yes ❑ No	Croup:	❑ Yes ❑ No
Heart Conditions:	❑ Yes ❑ No	Digestive Problems:	❑ Yes ❑ No	Lung Problems:	❑ Yes ❑ No
Kidney Problems:	❑ Yes ❑ No	Emotional Problems:	❑ Yes ❑ No	Cancer:	❑ Yes ❑ No
Back Pain:	❑ Yes ❑ No	Headaches:	❑ Yes ❑ No	Other:	❑ Yes ❑ 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 <u>ever</u> 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:	❑ Yes ❑ No	Inhaler Use:	❑ Yes ❑ No
Car Accident(s):	❑ Yes ❑ No	Prescription Medication:	❑ Yes ❑ No
Fall/Jump from a height <3 feet:	❑ Yes ❑ No	Surgery:	❑ Yes ❑ No
Fall/Jump from a height >3 feet:	❑ Yes ❑ No	Vaccinations:	❑ Yes ❑ No
Childhood Illness:	❑ Yes ❑ No	Youth Sports:	❑ Yes ❑ No
Head Trauma:	❑ Yes ❑ 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 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 invovled in a motor vehicle addicent 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 Sugery?	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. 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.

_____

Reponsible Party Signature Relationship Date

Healing Hands Chiropractic, LLC

Informed Consent for Chiropractic Care

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective. It is important that each patient understands both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiopractic care after being advised of known benefits, risks and alternatives.

Chiropractic is a science and art which concerns itself with the relationshiop between structure (primarily the spine) and function (primarily the nervous system) as that relationship may effect the restoration and preservation of health. **Health** is a state of optimal physical, mental and social well being, not merely the absence of disease or infirmity.

One disturbance to the nervous system is called a **vertebral subluxation**. This occurs when one or more of the 24 vertebra in the spinal column become misaligned and/or do not move properly. This causes alteration of nerve function and interference to nerve system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by an **adjustment.** An adjustment is the specific application of forces to correct vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine. Adjustments are usually done by hand but may be performed by handheld instruments. In addition, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be included.

If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risks and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

_____	_____	_____
Print Name	Signature	Date

Consent to evaluate and adjust a minor child:

I, _____ being the parent or legal guardian of _____ have read and fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care.

Pregnancy Release:
This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation, if necessary. I have been advised that x-ray can be hazardous to an unborn child. Date of last menstrual cycle: _____

_____	_____
Signature	Date

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Electronic Health Records Intake Form

In compliance with requirements for the government EHR incentive program

First Name:_____ **Last Name**:_____

Email address: _____@_____

Preferred method of communication for patient reminders (Circle one): Email / Phone / Mail

DOB: __/__/____ **Gender (Circle one):** Male / Female **Preferred Language:** _____

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

Smoking Start Date (Optional): _____

CMS requires providers to report both race and ethnicity

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) / Native Hawaiian or Pacific Islander / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications? (Please include regularly used over the counter medications)

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

☐ **I choose to decline receipt of my clinical summary after every visit** *(These summaries are often blank because of the nature and frequency of chiropractic care.)*

Patient Signature: _____ Date: _____

For Office Use Only

Height:_____ Weight:_____ Blood Pressure:_____/_____

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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 or Guardian
signature_____

Print Name if Guardian_____ Date_____

A copy of complete HIPPA policy is available by request.

____Refused to sign_____