

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 (C) _____ (W) _____ Phone (C) _____ (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? _____

o 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
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 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 she/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 she/he checked by a chiropractor? Yes No
- What sports or recreational activities does she/he do? _____
- Describe your child's most recent stress, strain, or injury while doing these activities? _____
- Was any care given? Yes No Was she/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. 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.

Reponsible Party Signature _____ Relationship _____ Date _____

HEALING HANDS CHIROPRACTIC, LLC

3 Hall Ave [Symbol] Wallingford CT 06492 [Symbol] 203-626-9994

TERMS OF ACCEPTANCE

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.

Chiropractic has only one goal. 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.

Adjustment: The adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: The state of optimal physical, mental and social well being, not merely the absence of disease or infirmity.

Vertebral subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer diagnosis or treat any disease. We only offer to diagnosis either vertebral subluxations or neuromusculoskeletal conditions. However, during the course of a chiropractic spinal examination we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of another health care provider.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations. However, we may use other procedures to help your body hold the adjustments.

I, _____ have read and fully understand the above statements.
(print name)

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction.

Therefore, I accept chiropractic care on this basis.

(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 terms of acceptance 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)

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 _____

Treatment Disclaimer

Is your treatment for any of the following? Please circle YES/NO

Worker's Comp **Yes** **No**

Personal Injury ** **Yes** **No**

Auto accident ** **Yes** **No**

Auto Accident on Company time **Yes** **No**

Health & Wellness **Yes** **No**

Other ie: slip/fall **Yes** **No** (If Yes, please explain) _____

I understand that if at any time during my care at Healing Hands Chiropractic, LLC it is deemed as Worker's Compensation that HHC does not participate in Workers Comp. If my care is found to be Workers Comp. HHC will provide notes at an additional fee, but will not provide reports, scans etc.

****Please note, If this is a Personal Injury or Auto case we require a Letter of Protection, Letter of Representation, and Medical Authorization PRIOR TO CARE BEING GIVEN.**

Date _____

Patient Signature

EZ-Pay Signature-On-File Authorization

I, _____, hereby authorize **Healing Hands Chiropractic, LLC** to initiate payments from my credit or bank account with the financial institution identified by me on this form for payment of services and/or products provided by **Healing Hands Chiropractic, LLC** not to exceed \$ _____ per transaction.

_____ (initial) I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify **Healing Hands Chiropractic, LLC** in writing of any changes in my account information or termination of this authorization at least 15 days prior to any further charges to my credit card or bank account. I certify that I am an authorized user of this credit card/bank account and will not dispute these transactions with my bank or credit card company; so long as the transactions correspond to the terms indicated in this authorization form. Notice to cancel can be given by either mailing to: 3 Hall Ave Wallingford, CT 06492 **or** faxing to: **203-284-3677**

Signature: _____ Date: _____

CREDIT CARD (last 4 digits) ____ ____ ____ ____ (Circle One) VI, MC, AM, DI

Card Holder's Printed Name: _____

Signature: _____ Date: _____

ACH BANK ACCOUNT (last 4 digits) ____ ____ ____ ____

Bank Name: _____

Bank Account Holder's Name: _____

If ACH Transactions are rejected for Non Sufficient Funds (NSF) I understand that **Healing Hands Chiropractic, LLC** may at its discretion attempt to process the charge again within 30 days, and agree to any additional **\$25.00** charges for each attempt returned NSF which will be initiated as a separate transaction.

Signature: _____ Date: _____

Billing Address Associated with Credit Card or Bank Account

Billing Address: _____ Phone: _____

City, State, Zip: _____

PRE-SCAN Checklist for: _____ Date _____

Your nervous system controls and regulates every cell of your body. We use an instrument that reveals how well your nervous system is working.

Please let us know if we need to be mindful of the following:



Drinking coffee or tea can excite the nervous system. Have you had any of these caffeinated beverages today?

No Yes
About ___ cups.

Cola drinks contain caffeine and chemicals that can affect the nervous system. How many sodas have you had today: _____.



Nicotine is a nervous system stimulant. Have you used any tobacco today?

No Yes How much: _____

Common, over-the-counter drugs can impact the nervous system. Have you taken any of these types of drugs today?

No Yes _____



Many prescription drugs and muscle relaxers affect the nervous system. Have you taken any type of prescription medication today?

No Yes _____

Excessive exposure to the sun affects the accuracy of your scan.

Have you had a sunburn in the last five days? No Yes



Bath salts, oils or sunscreen on your skin can influence instrument sensitivity.

Have you used any of these products today? No Yes

Vigorous physical activity can exaggerate your scan results.

Have you had a workout today? No Yes



Stress, depression, anxiety or emotional upsets can affect nervous system tension.

Compared to a typical day, are you currently experiencing an increased level of stress? No Yes