New England Chiropractic

Child Patient Intake

About the Child

Name____
Address_____________________________________
City______________________State___Zip_______
Home phone__________________________________
Birth date__________________________________
Age____________Gender__________Weight_____
Social Security #______________________________

About the Parent

Name____
Employer____________________________________
Work Address________________________________
Work phone_________Cell Phone______________
Occupation__________________________________
Marital Status______________________________
Social Security #____________________________

Vaccinations

Have you chosen to vaccinate your child? □yes □ no
If yes, check all that your child has received.
□ DPT □ MMR □Chicken Pox □ Hepatitis □ Other
Describe any and all reactions to vaccine(s).

____

Awareness of Chiropractic Principles

Were you aware that

	Yes	No
▪Doctors of Chiropractic work with the nervous system?	□	□
▪The nervous system controls all bodily functions and systems?	□	□
▪Chiropractic is the largest natural healing profession in the world?	□	□
▪If Chiropractic care starts at birth, you can achieve a higher level of health throughout life?	□	□

Mother's Pregnancy & Labor

Any problems during pregnancy?______________________________

How was your delivery?_________________
□ Labor chemically induced
□ Labor was Dr. assisted
□ C-section delivery □ Forceps/Vacuum extraction?
□ Did Dr. pull/twist baby? □ Premature delivery

Please explain___________________________

Did you nurse? □yes □no
Feeding problems? □yes □no

Has this child ever suffered from:

□ Chronic Earaches	□ Tubes in ears	□ Breathing Problems
□ Colic	□ Tuberculosis	□ Colds/ Flu
□ Sleeping Problems	□ Headaches	□ Asthma
□ Allergies	□ Digestive Disorders	□ Sinus Trouble
□ Constipation	□ Rheumatic Fever	□ Diarrhea
□ Poor Appetite	□ Hyperactivity	□ Behavioral Problems
□ Bed Wetting	□ Muscle Jerking	□ Attention Problems
□ Fainting	□ Walking Problems	□ Neck Problems
□ Rubella	□ Rubeola	□ Whooping Cough
□ Chicken Pox	□ Mumps	□ Measles
□ "Growing Pains"	□ Stomach Aches	□ Other ________________

Name ______________________ Date ______________________

Child's current health status

What is the purpose of this appointment?

____

What changes (if any) in your child's health or behavior would you like accomplished?

____

Does your child carry a backpack to school? If so, what kind? (One strap, size etc)

____

Has your child ever:	**Yes/No**	**If yes, please explain**
…taken antibiotics?	☐ ☐	______________
…been hospitalized?	☐ ☐	______________
…had a severe fall?	☐ ☐	______________
…been in a car accident?	☐ ☐	______________
…had surgery?	☐ ☐	______________
…been treated on an emergency basis?	☐ ☐	______________
…currently taking any medications?	☐ ☐	______________

Experience with Chiropractic

Who referred you to this office?______________________

Have you been adjusted by a Chiropractor before? ______________

Has any adult in your family seen a Chiropractor? ______________

Has any child in your family seen a Chiropractor? ______________

Goals for my Child's Care

People see Chiropractors for a variety of reasons. Some go for relief of pain, some to correct the cause of pain or various health problems and others for achieving an optimum and healthier lifestyle. Your doctor will weigh your needs and desires when recommending your child's care program. Please check the type of care desired so that we may be guided by your wishes whenever possible.

☐ **Relief care**-Symptomatic relief only

☐ **Corrective care**-Correcting the cause of the problem as well as the symptoms

☐ **Wellness Care**-Correction of problems and achieving a healthier lifestyle

☐ I want the Doctor to select the type of care appropriate for my condition

AUTHORIZATION FOR CARE OF MINOR

I HEREBY AUTHORIZE THIS CLINIC AND ITS DOCTORS TO ADMINISTER CARE AS THEY SO DEEM NECESSARY TO MY SON / DAUGHTER / WARD (Upon approval of parent or guardian).

Signed ______________ Witness ______________ Date __________

I REALIZE THAT I AM RESPONSIBLE FOR ALL FEES CHARGED BY THIS CLINIC AND THAT I WILL PAY FOR ALL SERVICES AS THEY ARE PERFORMED.

Signature ______________________________ Date __________

NEW ENGLAND CHIROPRACTIC

"Your Family Wellness Team"

KELLY LARSON-BRUNNER D.C.
WARREN MUNGER LAIN D.C.

1. You have the right to inspect and/or copy your health information for seven years from the date that the record was created or as long as the information remains in our files. In addition you have the right to request an amendment to your health information should be provided to us in writing.

We are required by the state and federal law to maintain the privacy of your patient file and the health protected health information therein. We are also required by the law to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice we will notify you in writing as soon as possible following the changes. Any change in our privacy notice will apply for all of your health information in our files.

Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules. If you would like further information or have a complaint about our privacy policies and practices please contact: Dr. Lain or Dr. Kelly.

2. It is the practice of this office to provide chiropractic care in an "open adjusting" environment. "Open adjusting" involves several patients being seen in the same adjusting room at the same time. Patients are within sight of one another and some ongoing routine details of care are discussed within earshot of other patients and staff. This environment is used for ongoing care and is NOT the environment used for taking patient histories, performing examinations or presenting reports of findings. These procedures are completed in a private, confidential setting.

We are requesting this authorization of you due to various interpretations under federal law with respect to what is known as an "incidental disclosures" of health information. It is our view that the kinds of matters related in an "open adjusting" environment are incidental matters, in the event you or someone else would not agree with us we are providing this disclosure.

3. It is our desire **for our staff to use your name, address, E-mail and/or telephone number for the purpose of contacting you** to advise you about health related meetings, workshops, and products. We may also call to remind you of scheduled appointments, re-evaluations, appointment related issues, or other special events (birthdays, functions, etc.)

The use of this information and format of "open adjusting" is intended to make your experience with our office more efficient and productive as well as to enhance your access to quality health care and health information. If you choose not to be adjusted in an open-adjusting environment other arrangements will be made for you. Your decision will have no adverse effect on your care from the doctors or on your relationship with our staff.

4. Your signature indicates your authorization of this activity.

______________________	______________________________	________
Name of child (printed)	**Guardian Signature**	**Date**

This authorization may be revoked by you at any time. Revocation may be accomplished by advising us in writing of your desire to withdraw your authorization. Please allow a reasonable processing time for the change in our procedures to be completed.