

"The power
that made the body
heals the body"
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**Deerfield Family
Chiropractic**

Pediatric Intake Form

Date: _____

PERSONAL INFORMATION

Child's First Name: _____ M.I.: _____ Last Name: _____

Preferred Name: _____ Social Security Number: _____

Address: _____

City / State / Zip: _____

Birth Date: _____ Age: _____ Sex: M F

of Siblings: _____ Sibling's Names & Ages: _____

Parents' Names: _____

Best Contact Phone: () _____ Alternate Phone: () _____

Parent's Email: _____

Who can we thank for referring you or how did you hear about our office? _____

REASON FOR SEEKING CARE

What is your reason for seeking care at Deerfield Family Chiropractic? _____

When did this begin? (If applicable) _____

Are there any major injuries and/or surgeries we should know about? _____

What is this affecting that is MOST important in your child's life? (List all that apply)

Has your child seen any other providers for this condition? (List all that apply)

Has your child seen a chiropractor before? Yes No

How long ago? _____ Clinic/Doctor Name: _____

What is your reason for the change? (If applicable) _____

What is your level of commitment to your child's health? | 2 3 4 5 6 7 8 9 10

Explain: _____

What health goal, if your child were to complete or accomplish it, would have the greatest impact on his/her your life?

HEALTH CONCERNS

- | | |
|--|--|
| <input type="checkbox"/> Anxiety/Depression | <input type="checkbox"/> Fatigue/Sleep Issues |
| <input type="checkbox"/> Constipation/Diarrhea | <input type="checkbox"/> Asthma/Chronic Bronchitis |
| <input type="checkbox"/> Nausea/Vomiting | <input type="checkbox"/> Colic/Acid Reflux |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Back/Neck Pain/Stiffness |
| <input type="checkbox"/> Bed Wetting | <input type="checkbox"/> Difficulty Gaining Weight |
| <input type="checkbox"/> Overweight | <input type="checkbox"/> Ear or Other Infections |
| <input type="checkbox"/> Frequent Sickness | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Learning Disorders |
| <input type="checkbox"/> Detachment/Distant | <input type="checkbox"/> Sinus Troubles/Allergies |
| <input type="checkbox"/> Irritability/Nervous | <input type="checkbox"/> Autism/Asperger's |
| <input type="checkbox"/> Other _____ | |
| <input type="checkbox"/> Other _____ | |
| <input type="checkbox"/> Other _____ | |

Explain any boxes checked above:

Is there anything else regarding your child's current condition you feel the doctor should know? _____

MEDICATIONS

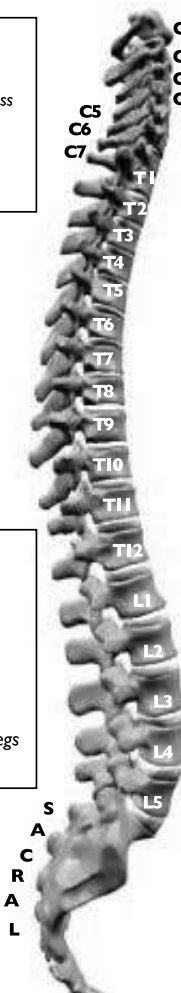
- | | |
|---|--|
| <input type="checkbox"/> Anxiety/Depression | <input type="checkbox"/> Migraine/Headache |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Acid Reflux |
| <input type="checkbox"/> Pain Narcotics | <input type="checkbox"/> ADD/ADHD |
| <input type="checkbox"/> Antibiotics | <input type="checkbox"/> Digestive |
| <input type="checkbox"/> Other _____ | |
| <input type="checkbox"/> Other _____ | |
| <input type="checkbox"/> Other _____ | |

Explain any boxes checked above:

DID YOU KNOW...

Each health concern relates to a specific area of the spine and nervous system? Please circle below or enter the information to the left.

- Sore Throat
- Stiff Neck
- Radiating Arm Pain
- Hand/Finger Numbness
- Asthma
- Allergies
- High Blood Pressure
- Heart Conditions



- Headaches
- Migraines
- Dizziness
- Sinus Problems
- Allergies
- Fatigue / Sleep Problems
- Head Colds
- Vision Problems
- Difficulty Concentrating
- Hearing Problems

- Middle Back Pain
- Congestion
- Difficulty Breathing
- Bronchitis
- Pneumonia
- Gallbladder Conditions
- Stomach Problems
- Ulcers
- Gastritis
- Kidney Problems
- Indigestion

- Constipation
- Colitis
- Diarrhea
- Gas Pain
- Irritable Bowel
- Bladder Problems
- Menstrual Problems
- Low Back Pain
- Pain or Numbness in Legs
- Reproductive Problems

VITAMINS / SUPPLEMENTS

- | | |
|--|---|
| <input type="checkbox"/> Multi-Vitamin | <input type="checkbox"/> Fish Oil/Omega-3 |
| <input type="checkbox"/> Vitamin D3 | <input type="checkbox"/> Probiotics |
| <input type="checkbox"/> Other _____ | |
| <input type="checkbox"/> Other _____ | |
| <input type="checkbox"/> Other _____ | |

Explain any boxes checked above:

PRENATAL HISTORY

Location of birth: Home Birthing Center Hospital Other: _____

Did any of the following happen during delivery:

C-section delivery - Doctor pulled or twisted baby - Anesthesia - Labor was induced

Forceps/vacuum extraction - Premature delivery - Special medical procedures/tests

Describe any of the above plus any additional complications experienced during delivery:

During pregnancy, did you use any drugs, tobacco, alcohol, and/or medications? If yes, please list:

Did you experience any illness while pregnant? Yes No If yes, explain: _____

Do you have any physical disabilities? Yes No If yes, explain: _____

Birth weight: _____ Birth length: _____ APGAR scores (if remembered): _____

Ultrasound used during pregnancy? Yes No Number of times: _____

Did you breastfeed the baby? Yes No If yes, how long: _____

Did you formula-feed the baby? Yes No If yes, how long: _____

At what age did you introduce: Solids: _____ Cow's milk: _____

LIFESTYLE HABITS

Does your child exercise daily? Yes No How much? _____

Does your child drink soda? Yes No How much/often? _____

Does your child have a positive self-esteem or self-image? Yes No

Does your child watch more than an hour of TV per day? Yes No How much? _____

Does your child eat balanced meals? Yes No

Does your child experience prolonged sadness? Yes No Explain: _____

Does your child have difficulty sleeping? Yes No Explain? _____

Does your child play video games? Yes No How much? _____

CURRENT HEALTH STATUS

The National Safety Council reports approximately 50% of children fall head first from a high place during their first year of life (bed, changing table, stairs, etc.). Was this the case for your child? Yes No Explain: _____

Has your child ever been hospitalized or had surgery? Yes No Explain: _____

Does your child have difficulty interacting with others? Yes No Explain: _____

Have you noticed that your child is nervous, twitches, shakes, or exhibits rocking behavior? Yes No Explain:

Has your child been involved in any high impact/contact sports (soccer, football, martial arts, cheerleading, etc.)? Yes No
Please list: _____

Are you aware of any food allergies or intolerance? Yes No Explain: _____

Has your child received all recommended vaccinations? Yes No Explain: _____

Please rate stress levels on a scale of 1-10 (10 being highest)

School: 1 2 3 4 5 6 7 8 9 10 Personal: 1 2 3 4 5 6 7 8 9 10

PERMISSION TO TREAT A MINOR

I, (Parent/Guardian) _____, give Deerfield Family Chiropractic permission to examine, x-ray (if necessary), and treat _____.

Minor date of birth: _____

Parent/Guardian Signature: _____ Date: _____

Witness Signature: _____

Print Patient's Name: _____ Date: _____

FINANCIAL POLICY

Our goal is to provide the highest quality of healthcare possible for our patients. In order to achieve this goal, we need your commitment as well.

- We urge our patients to follow the doctor's recommendations for care. Please keep your appointments as scheduled or call our office within 24 hours to make any changes. In order to attain the level of achievement we both desire, your care plan must be followed.
- **A \$25 fee will be charged to your account for any appointments missed without a 24 hour notice of cancellation. We require a credit or debit card on file due to this policy.**
- I authorize Deerfield Family Chiropractic to release any information deemed appropriate concerning my physical condition to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred by me.
- In order to file your claims in a timely manner (if applicable), we need current, accurate insurance information for you and your dependents. We will do our best to confirm your eligibility and level of insurance coverage for care; however, it is ultimately your responsibility to know your own insurance benefits. Should your insurance carrier determine that any or all of our services are ineligible for payment, you will be billed directly for those services.
This office will prepare any necessary reports and forms to assist me in making collection from the insurance company. Any amount authorized to be paid directly to this office will be credited to my account. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment.
- Late payment for non-coverage, deductible, and co-payment will be subject to an 18% annual finance charge, which will be added monthly to your account.
- If you have any questions about our financial policies, please speak with our staff. If you need to make special payment arrangements, we will do everything possible to meet your financial needs.

Parent/Guardian Signature: _____ Date: _____

CONSENT TO CHIROPRACTIC SERVICES

I hereby request and consent to chiropractic adjustments and other procedures (therapeutic treatment if necessary) by Elizabeth Eyles and her staff who now or in the future treat my child while employed by this office. I will have an opportunity to discuss with Dr. Elizabeth Eyles and/or with other clinic personnel the nature and purpose of treatment indicated. I understand that results are not guaranteed. While chiropractic treatment is remarkably safe, you need to be informed about the potential risks related to your care to allow you to be fully informed before consenting to treatment. Please inquire if you have further questions. I do not expect the Doctor to be able to anticipate and explain all risks and complications, and wish to rely on the Doctor to exercise judgment during the course of any procedure which the Doctor feels at the time is in my best interest. I understand that Deerfield Family Chiropractic will not be held responsible for any pre-existing medical conditions. I certify that the information contained in my health history is correct to the best of my knowledge. I will not hold my doctor or any staff member of Deerfield Family Chiropractic responsible for any errors or omissions that I may have made in the completion of this form. I have read, or have had read to me, the full above consent and have also had an opportunity to ask questions about its content and by signing below I agree to the above terms and procedures. I intend this consent to cover any treatment for my child's present condition and for any future care provided by this clinic and/or employed staff.

Parent/Guardian Signature: _____ Date: _____

Witness: _____ Date: _____