Pediatric Intake Form (Birth to 12 years old)

Date:______________________

Patient Information:

Child's Name ____ Date of Birth ____________
Last First Middle

Parent / Guardian Name____ Date of Birth ____________
Last First Middle

(Complete Mailing)
Address ____
Street Apt# City State Zip

Home Phone # ______________________** Work Phone # ____________________________**

Cell Phone #________________________** Email address______________________________

*If you would like to opt-out of receiving email notifications from our office, please initial here______***

How did you hear about us? *Referral | Mail | Website | Phonebook | Internet search | Insurance*
*Who may we thank for referring you to our office?*____

Is this visit routine/accident/illness/other: _________________ If Accident (date)___________

Insurance and Payment Information

Do you intend to use health insurance? ☐ Yes ☐ No
Are you covered by Medicare? ☐ Yes ☐ No
Are you covered by Medicaid? ☐ Yes ☐ No

Insurance Information: Ins. Company____
Policy holder name/Date of Birth/Relation(*if different than above*) ______________________________
Insurance ID#_______________________ Group ID#_____________________ Copay?_________

Please notify our staff if there is an alternate address / phone number or form of communication that you wish us to contact you by other than your listed information above. Your information will never be sold, shared or distributed.

Other Pediatric Provider Name/Phone #:____

Has your child seen a chiropractor before? ☐ Yes ☐ No
Previous Chiropractor Name / Phone #: ____

ACKNOWLEDGEMENT AND UNDERSTANDING

Please initial each item below.

1. ______I hereby authorize City Fit Family Chiropractic Center LLC and the doctors on staff to provide Chiropractic and other necessary health care services for my child as they deem appropriate.

2. ______I understand and agree that all services rendered to my child at this office are my responsibility, regardless of insurance coverage. I have read and signed the clinic financial policy and understand that even if submitted to insurance, I am ultimately personally responsible for payment.

3. ______If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and cost of collections.

4. ______I hereby assign all chiropractic benefits, including major medical benefits to which my child is entitled, Medicare, private insurance and all other health plans, to Andrea L Herrst, DC and City Fit Family Chiropractic Center LLC, 510 SW 3rd Ave, Suite 210, Portland OR 97204, pursuant to the clinic financial policy I have signed.

5. ______I authorize release of patient records to third parties requiring these records for determination of financial liability

6. ______I authorize release of my child's personal health records (including chart notes, x-rays, examination forms, et al) to Andrea L Herrst, DC and City Fit Family Chiropractic Center LLC, and to requesting third parties with proper authorization, for purposes of coordinating and informing my treatment while under care in this office. I can revoke this authorization by submitting a written notice to Andrea L Herrst, DC, c/o City Fit Family Chiropractic Center LLC, 510 SW 3rd Ave, Suite 210, Portland OR 97204.

7. ______Email: Email is not to be used for appointment scheduling, sensitive and/or urgent matters. Reply times will depend on when email is accessed and can range from one to several days. Please be aware that Dr. Herrst may not access email while on vacation. Email may entail some privacy risks and ***is not HIPAA compliant***. If you choose to communicate by email, you accept this risk. Please be concise; if Dr. Herrst cannot answer you very briefly, the matter is probably more complicated and should be addressed at the next office visit. If you choose to communicate by email, Dr. Herrst reserves the right to charge a consultation fee for these services if necessary.

By signing this application I affirm that I have given true and complete information.

Dated this _________day of _______________ 20_____.

____

Guarantor Signature **Relationship to Patient**

AUTHORIZATION TO TREAT A MINOR

As a parent or legal guardian having legal custody or guardianship of the below named minor child, authorize, request and direct Dr. Andrea L Herrst, DC and whomever she may desginate as assistant to perform in judgment any examination, diagnosis and chiropractic or other appropriate treatment deemed advisable and as explained in the informed consent I have read and signed.

____

Patient's full name Date of Birth

Signature___________________________________Date____________Witnessed by___________________
(Parent or Guardian)

Childs' Name: ________ **Date of Birth:** ________ **M / F** **Date:** ________

Prenatal History

Is your child adopted? ❑ Yes ❑ No
Did you have any pregnancy-related complications? ❑ Yes ❑ No
If yes, please describe____
Place of birth: ❑ Home ❑ Birthing Center ❑ Hosptial
Provider: ❑ Midwife ❑ OB-GYN ❑ Other:____________________
Type of Birth: ❑ Vaginal ❑ C-section

Were pain medications used? ❑ Yes ❑ No
Was labor induced? ❑ Yes ❑ No
If yes, please describe____
What position did you deliver in? ❑ Squatting ❑ On Back ❑ Water birth Other:__________
Was labor assisted by: ❑ Doctor pulling ❑ Vacuum ❑ Forceps ❑ None

Did your child have a misshapen skull or head? ❑ Yes ❑ No
Were there purple markings on their face? ❑ Yes ❑ No

Medical History

Did you breast feed your child? ❑ Yes ❑ No
Does your child prefer one breast over the other? ❑ Yes ❑ No
If yes, which side? ❑ Right ❑ Left

Has your child been immunized? ❑ Yes ❑ No
Reason for immunization: ❑Informed decision ❑Recommended ❑Didn't know I had a choice

Did your child have any negative reaction to the vaccinations? ❑ Yes ❑ No
If yes, were they reported? ❑ Yes ❑ No

Has your child had any surgeries? ❑ Yes ❑ No
If yes, please describe____

Is your child currently taking any medications? vitamins? ❑ Yes ❑ No
If yes, please describe____

Baby / Toddler (age 0-4)

Have any of the following occurred? (please circle)

Fall from changing table	Frequent crying spells	Tumble down stairs	Car accident
Fall out of crib	Fall on playground	Frequent ear infections	Tonsillitis
Frequent fevers	Frequent diarrhea	Constipation	Colic
Sleeping problems	Frequent colds	Weight gain / loss	Other

Child (age 5-12)

Have any of the following occurred? (please circle)

Fall from a tree	Fall off a bicycle	Sports accident	Car accident
Stomach pains	Scoliosis	Bed wetting	Fall on playground
Hyperactivity	Autism	Asthma	Allergies
Leg / knee pains	Growing pains	Other	

Daily Habits and Activities

Does your child participate in any of the following *(please circle)*

Soccer	Football	Gymnastics	Karate	Hockey	Lacrosse	Basketball
Wrestling	Baseball	Softball	Volleyball	Tennis	Dance	Swimming

Other Sport:____________________

How would you rate your child's diet? Well balanced Average High sugar / processed foods
Does your child consume artificial sweeteners? ❑ Yes ❑ No
Does your child drink water? ❑ Yes ❑ No
Number of hours your child sleeps? ________Hours per day Sleep quality? ❑Good ❑Fair ❑Poor

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Child's Name: ____________ **Date of Birth:** ________ **M / F** **Date:** ________

Please tell us about your child's health. Please place an **X** in the box if the the sentence applies to your child. This will help your doctor plan your child's physical exam.

Growth

☐ I am concerned about my child's growth.

Appetite

☐ I am concerned about my child's eating / feeding habits or appetite.

Rest

☐ I am concerned about the amount of sleep my child needs or is not getting.

Illness/Surgery/Injury

☐ My child had a serious illness, injury or surgery. *Please describe*______________________

____

Physical Activity

☐ My child must restrict physical activity. *Please describe*______________________________

____

Development and Learning

☐ I am concerned about my child's behavior, development or learning. *Please describe*_______

____

Allergies

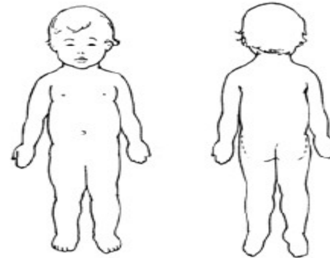
☐ My child has allergies (medicine, food, dust, mold, pollen, insects, animals, etc) *Please describe*_____________________________________

Body Health

My child has problems with

☐ Skin, birthmarks, Mongolian spots, hair, fingernails, toenails.

Please map and describe color/shape of skin markings, birthmarks, scars, moles, etc, on the figure below.



☐ Eyes / vision, glasses

☐ Ears / hearing, hearing aides or device, earaches, tubes in ears

☐ Nose problems, nosebleeds, runny nose

☐ Mouth, teething, gums, tongue, sores in mouth or on lips, mouth-breathing, snoring

☐ Frequent sore throats or tonsillitis

☐ Breathing problems, asthma, cough, croup

☐ Heart, heart murmur

☐ Stomach aches, upset stomach, colic, spitting up, vomitting

☐ Using toilet, toilet training, urinating, bed wetting

☐ Bones, muscles, movement, pain with movement, problems with moving to one side

☐ Nervous system, headaches, seizures, nervous habits (like twitches)

☐ Needs special equipment. *Please describe*

____

☐ Sleep, sleep walking, head rolling

Parent Questions or Comments for Doctor:

____

____

____

____

____

Parent or Guardian Signature Date

____________________________________ Clinician Signature / Date