Initials _____

POWER
CHIROPRACTIC & WELLNESS

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PEDIATRIC INTAKE FORM

Build A Healthy Foundation.

Welcome to the Power Chiropractic community!

- **First, please initial the top corner of each page.**
- **For any question that does not apply to your child, simply respond "N/A" for Not Applicable.**

Today's Date: _____

Has your child ever received chiropractic care? ☐ No ☐ Yes, (Please list the City, State, & Doctor):

_____

Has anyone in your child's family ever received chiropractic care? ☐ No ☐ Yes, (Please list the City, State, & Doctor): _____

Who can we thank for referring you to our office? _____

PERSONAL INFORMATION

Child's Full Name: _____
Child's Preferred Name: _____
☐ Male ☐ Female
Weight: _____lb. _____oz. Height: _____ft. _____in.
Date of Birth: _____ Age: _____
Address: _____
City: _____ State: _____
Zip:_____
List Your Child's Regular Physical Activities:
_____
_____
_____
List Your Child's Hobbies & Interests:
_____
_____
_____
List The Name(s) & Age(s) of Your Child's Sibling(s):
_____
_____

Full Name of Parent/Guardian #1:
_____
Phone: _____ ☐Home ☐Work ☐Cell
Cell Phone Provider: _____
Email: _____
Occupation: _____
Employer: _____

Full Name of Parent/Guardian #2:
_____
Phone: _____ ☐Home ☐Work ☐Cell
Cell Phone Provider: _____
Email: _____
Occupation: _____
Employer: _____

Family Member(s) Responsible For Finances:
☐ Parent/Guardian #1 ☐ Parent/Guardian #2
☐ Both Parents/Guardians #1 & #2
☐ Other: _____
Other's Phone #: _____

INSURANCE INFORMATION

Select which is true for your child: ☐ Self Pay ☐ Insured, **(Please record the following information)**

Primary Insurance: _____
Member ID #: _____
Policy Holder's Name: _____
Policy Holder's Date of Birth: _____
Policy Holder's Employer: _____

Secondary Insurance: _____
Member ID #: _____
Policy Holder's Name: _____
Policy Holder's Date of Birth: _____
Policy Holder's Employer: _____

HEALTH GOALS

Select all of the current health and lifestyle goals for your child:

☐ Improve Posture
☐ Get Adequate Sleep
☐ Drink More Water
☐ Increase Energy
☐ Improve Diet/Nutrition
☐ Improve Focus/Concentration
☐ Increase Self Confidence
☐ Restore Emotional Health
☐ Strengthen Immune System
☐ Maintain Healthy Body Weight
☐ Improve Athletic Performance
☐Other: _____
_____
_____
_____

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CASE HISTORY

Does your child have any genetic disorders or disabilities? ☐ No ☐ Yes, (Explain): _____

_____

Has your child ever had a serious illness or health emergency? ☐ No ☐ Yes, (List all condition(s) including the year): _____

Has your child ever had an operation? ☐ No ☐ Yes, (List all operation(s) including the year):

_____

Has your child ever been in an auto accident? ☐ No ☐ Yes, (Include the year): _____

Has your child ever been unconscious? ☐ No ☐ Yes, (Explain): _____

_____

Has your child ever fractured a bone? ☐ No ☐ Yes, (Explain): _____

_____

Does your child have any allergies? ☐ No ☐ Yes, (Explain): _____

Has your child ever taken an antibiotic drug? ☐ No ☐ Yes, (Include times per lifetime): _____

Is your child taking any over-the-counter or prescription drug, vitamin / supplement, or natural remedy?

☐ No ☐ Yes, **(Please list the name & reason for taking):** _____

_____

PRENATAL HISTORY

Complete this section if your child is younger than 5 years of age.

Name of ☐ Obstetrician / ☐ Midwife: _____

Ultrasounds during pregnancy? ☐ No ☐ Yes, (How many?): _____

Complications during pregnancy / delivery? ☐ No ☐ Yes, (Explain): _____

_____

List any drug / medication, vitamin / supplement, or natural remedy taken during pregnancy / delivery:

_____

Location of birth: ☐ Hospital ☐ Birthing Center ☐ Home ☐ Other: _____

Childbirth delivery method: ☐ Vaginal ☐ Planned Cesarean Section ☐ Emergency Cesarean Section

☐ Vaginal Birth After Cesarean ☐ Vacuum Extraction ☐ Forceps

Birth Weight: _____lb. _____oz. Birth Length: _____ft. _____in. APGAR Scores: _____ - _____

Was / is your child breast fed? ☐ No ☐ Yes, (For how long?): _____

Was / is your child formula fed? ☐ No ☐ Yes, (For how long?): _____ Formula type: _____

Was your child introduced to cow's milk? ☐ No ☐ Yes, (At what age?): _____

According to the National Safety Council, approximately 50% of children fall head first from a high place during their first years of life (i.e. a bed, changing table, down stairs) Did your child have a fall similar to this?

☐ No ☐ Yes, Explain: _____

_____

CURRENT SYMPTOMS

Select which is true for your child:

☐ My child **DOES NOT** have symptoms. I am seeking chiropractic care for my child to maintain wellness.
(If above is selected, move ahead to the "INITIAL ASSESSMENT" section)

☐ My child **DOES** have symptoms.
Select all of the symptom(s) that has you seeking chiropractic care for your child:

☐ ADHD/ADD	☐ Autism	☐ Ear Infections	☐ Restless Sleep
☐ Allergies	☐ Back Pain	☐ Epilepsy	☐ Scoliosis
☐ Anxiety	☐ Bed Wetting	☐ Growing Pains	☐ Temper Tantrums/Moody
☐ Asthma	☐ Colic	☐ Headaches	☐ Other: _____
☐ Athletic Injury	☐ Digestive Problems	☐ Recurring Colds/Fevers	_____

When did your child's symptom(s) begin? ☐ Today ☐ Days Ago ☐ Weeks Ago ☐ Months Ago ☐ Years Ago

Did your child's symptom(s) begin as a result of an injury? ☐ No ☐ Yes, (Explain): _____

_____

What have you already tried that **HAS NOT** helped to relieve your child's symptom(s)? _____

_____

What have you already tried that **HAS** helped to relieve your child's symptom(s)? _____

_____

Initials _____

INITIAL ASSESSMENT

NAME:_____ DATE:_____

Select which is true for your child.

☐ My child **DOES NOT** have symptoms. **(If selected, move ahead to the "STRESS ASSESSMENT" section.)**
☐ My child **DOES** have symptoms. **(If selected, use the "EFFECT SCALE" to answer the statements below.)**

EFFECT SCALE





0	1 2 3	4 5 6	7 8 9	10
NO EFFECT	**MILD EFFECT**	**MODERATE EFFECT**	**LIMITING EFFECT**	**SEVERE EFFECT**
I am free from any symptom. I can do all of my daily activities. My quality of life is good. I am grateful for my good health.	I barely notice the symptom. I can do most of my daily activities. I don't think much about the symptom, but it does cause me some discomfort.	I notice the symptom and it causes me distress. I can do some of my daily activities. I can only ignore the symptom for a short period of time.	I experience constant distress from the symptom. I am unable to do many of my daily activities. I can not ignore the symptom, it disrupts my ability to think clearly, hold a job, and maintain social relationships.	I am in distress and excruciating pain from the symptom. I am unable to do any of my daily activities. I am weak, delirious and bedridden. (Very few people ever experience this level of pain. Suicide is often considered.)

Use the 0-10 "EFFECT SCALE" above to base your answer for each statement below.
List your child's symptom, then read each statement and place an "X" in the box to mark your rating.

List your child's main symptom here: _____	0	1	2	3	4	5	6	7	8	9	10
ON AVERAGE, rate the effect of your symptom.											
RIGHT NOW, rate the effect of your symptom.											
AT ITS BEST, rate how close to "0" your symptom gets.											
AT ITS WORST, rate how close to "10" your symptom gets.											

If your child has another symptom, List it here: _____	0	1	2	3	4	5	6	7	8	9	10
ON AVERAGE, rate the effect of your symptom.											
RIGHT NOW, rate the effect of your symptom.											
AT ITS BEST, rate how close to "0" your symptom gets.											
AT ITS WORST, rate how close to "10" your symptom gets.											

If your child has another symptom, List it here: _____	0	1	2	3	4	5	6	7	8	9	10
ON AVERAGE, rate the effect of your symptom.											
RIGHT NOW, rate the effect of your symptom.											
AT ITS BEST, rate how close to "0" your symptom gets.											
AT ITS WORST, rate how close to "10" your symptom gets.											

*** If your child has more then 3 symptoms, simply ask a team member for another form.**

STRESS ASSESSMENT

Select all of the emotional, physical, and chemical stress your child has experienced in the past 3 months:

☐ Slip / Falls
☐ Car Accident
☐ Sports Injury
☐ Depression
☐ Anxiety
☐ Poor Diet / Nutrition
☐ Excessive Sitting
☐ Excessive Standing
☐ Lack of Exercise
☐ Increase of Exercise
☐ Lack of Sleep
☐ Death of A Loved One
☐ Hospitalization
☐ Surgery / Operation
☐ Change In Medication
☐ Occupational Stress
☐ Financial Stress
☐ Other: _____
_____
_____

Initials _____

ACTIVITIES OF DAILY LIVING

Complete if your child is <u>older than 5 years of age.</u> Read each activity listed below and place an "X" in the box to rate if your child feels any symptom(s) when doing the activity. Use the 0-10 "EFFECT SCALE" from the previous page to base your answer. Select "N/A" for any activity Not Applicable to your child.

0	1	2	3	4	5	6	7	8	9	10
NO EFFECT	MILD EFFECT			MODERATE EFFECT			LIMITING EFFECT			SEVERE EFFECT

PERSONAL HYGIENE & DAILY CARE

ACTIVITY	RATING												ADDITIONAL NOTES:
	N/A	0	1	2	3	4	5	6	7	8	9	10	
Bathing / Showering													
Grooming Hair													
Brushing Teeth													
Using The Toilet													
Dressing The Upper Body													
Dressing The Lower Body													

DAILY PHYSICAL ACTIVITIES

ACTIVITY	RATING												ADDITIONAL NOTES:
	N/A	0	1	2	3	4	5	6	7	8	9	10	
Standing													
Sitting													
Squatting													
Kneeling													
Reaching Overhead													
Bending Forward													
Turning Left													
Turning Right													
Move From Lying to Sitting													
Move From Sitting to Standing													
Move From Standing to Sitting													

FUNCTIONAL ACTIVITIES

ACTIVITY	RATING												ADDITIONAL NOTES:
	N/A	0	1	2	3	4	5	6	7	8	9	10	
Sleeping													
Eating													
Going Up & Down Stairs													
Getting In & Out of Car													
Driving													
Using A Computer													
Focusing/ Concentrating													
Preparing Food													
Household Chores													
Lifting Children													
Carrying Bag / Purse													

SOCIAL, RECREATIONAL, & OTHER ACTIVITIES

ACTIVITY	RATING												ADDITIONAL NOTES:
	N/A	0	1	2	3	4	5	6	7	8	9	10	
Competitive Sports													
Running / Jogging / Hiking													
Other Recreation Activities													
Hobbies													
Sexual Activity													

Initials _____

FAMILY HEALTH HISTORY

Place an "X" in the box below to show if your child's family members have ever had the following conditions.

- **If there is more than one family member per category, use an "X" to represent each individual.**
- **If you are filling this form out for your child, use "SELF" to represent your child's conditions.**

CONDITION	SELF	SIBLING(S)	FATHER	MOTHER
Acid Reflux / Heartburn / GERD				
ADD / ADHD				
Allergies				
Anxiety				
Arthritis / Joint Pain				
Asthma / Difficulty Breathing				
Bed Wetting				
Birth Defect				
Cancer				
Colic				
Convulsions / Epilepsy				
Deceased				
Depression				
Diabetes				
Digestive Problems				
Disc Problems				
Ear Problems / Hearing loss				
Fibromyalgia / Muscle Pain				
Frequent Cold / Flu				
Gall Bladder Problems				
Headache / Migraines				
Heart Problems				
High / Low Blood Pressure				
HIV / AIDS				
Impotence / Sexual Dysfunction				
Kidney Problems				
Learning Disability				
Liver Problems				
Menstrual Dysfunction				
Mood Changes / Irritable				
Neck Pain / Back Pain				
Prostate Problems				
Sciatica				
Scoliosis				
Sinus / Drainage Problems				
Skin Problems				
Sleep Problems				
Thyroid Problems				
Tremors				
Vertigo / Dizziness				
Vision Problems				
Other:				

Initials _____

POWER
CHIROPRACTIC & WELLNESS

INFORMED CONSENT FOR CHIROPRACTIC CARE

I hereby consent to give the doctor of chiropractic, and anyone working in the Power Chiropractic office authorized by the chiropractor, permission and authority to care for my child (the minor listed here: _____ for whom I am legally responsible). Chiropractic tests, diagnosis, analysis, and adjustments are very safe and beneficial and rarely cause any risks. In rare cases, underlying physical defects, deformities or pathologies may make your child prone to injury. It is the responsibility of the child's parent/guardian to make it known, or to learn through health care procedures if your child is suffering from latent pathological defects, illnesses, or deformities, which would otherwise not come to the attention of the chiropractor. The doctor of chiropractic will not give any treatment or care if he or she is aware that such care should not be used for a particular condition or circumstance. Your child's doctor of chiropractic is a licensed primary care provider, and is available to work with all other types of providers. I understand that if
my child is accepted as a Patient at Power Chiropractic, I am authorizing them to proceed with any treatment that they deem necessary. I understand that following the doctor's recommend care plan is essential to maximizing my child's healing and reaching optimal health through chiropractic. Furthermore, any questions that I have regarding chiropractic care, will be explained to me upon my request.

AUTHORIZATION FOR X-RAYS

Specific postural x-rays may be necessary for the identification of the location, type, and severity of vertebral subluxation, as well as for the diagnosis and identification of latent or dangerous conditions requiring medical attention. X-rays may also be used to show progress after a period of recommended chiropractic care. At your request, you can received a copy of your child's x-rays to a disc for the mandated fee of $29.00. By signing this page below, I authorize to perform diagnostic x-rays of my child if medically necessary.

Select which is true for your female child:

☐ To the best of my knowledge, there is no chance that my child is pregnant at this time.
☐ I know or believe that my child may be pregnant at this time and therefore I DO NOT authorize Power Chiropractic to perform diagnostic x-rays of her.

AUTHORIZATION FOR RELEASE OF INFORMATION & ASSIGNMENT OF BENEFIT

By signing below, I recognize that I am financially responsible for all services rendered to my child regardless of insurance or benefit. I further understand that any health insurance policy is an arrangement between me and my child's insurance carrier and that I may be required to pay for some or all of the fees charged to
my child's account. I hereby authorize Power Chiropractic to release all necessary information concerning my child's health condition to any billing company, insurance company, attorney, and/or adjuster in order to
process any claim for reimbursement of charges incurred by my child. In addition I authorize Power Chiropractic to release any information regarding my child's health condition to other health care providers involved in my child's care. This assignment will remain in effect until revoked by me in writing. I agree that a photocopy of this form is to be considered as valid as the original. I confirm that all information I have provided is true and correct to the best of my knowledge. I confirm that I have read and fully understand this
agreement and authorize Power Chiropractic to proceed with chiropractic care.

Signature of Practice Member or Parent/Guardian _____ Date _____

Initials _____

NOTICE OF PRIVACY PRACTICES

This notice describes how health information about your child may be used and disclosed and how you can get access to your child's health information and records. Power Chiropractic, understands the importance of privacy and we are committed to maintaining the confidentiality of your child's protected health information **(PHI)** in compliance with the Health Insurance Portability and Accountability Act of 1996 **(HIPAA)**. We have developed office policies and procedures that protect your child's personal and health information when used within our office and any devices used to copy or transfer this data. We assure you that your child's information will only be shared as required and only for the purpose of administering your child's case and obtaining payment for services. Be assured that without your permission, your child's health information will not be used for any other purpose.

The following ways are how your child's PHI may be used within our office to provide you the best care and services possible:

- To provide treatment, obtain payment, and conduct health care operations.
- To schedule appointments and send reminders.
- To communicate with your child's family, friends, and/or caregivers with your authorization.
- As permitted or required by the law.
- For certain activities when the law requires it.

The following describes your rights regarding your child's (PHI). You may:

- Request to inspect any copy of your child's records.
- Request to amend incomplete or inaccurate information in your child's records.
- Receive an accounting of certain disclosures of your child's health information.
- Ask for additional privacy protections (although your request may be declined).
- Ask for confidential communications in a particular manner.
- Receive a paper copy of this Notice.
- File a complaint without penalty

Power Chiropractic reserves the right to change this privacy policy as allowed by law and to make the new notice apply to health information already received as well as any information received in the future. A copy of our current notice is available upon request. The notice will contain the effective date.

If you believe that we have not properly respected the privacy of your child's PHI, you may file a complaint with our office by calling (615) 227-5020, sending a letter to our office address: 4117 Gallatin Rd. Nashille, TN 37216.

I confirm that I have received and reviewed this notice and understand how health information about my child may be used and disclosed and how I can get access to my child's health information and records.

Signature of Practice Member or Parent/Guardian

_____

TESTIMONIAL CONSENT

IN OFFICE	I DO	I DO NOT
Photographs		
Written Testimonials		
Video Testimonials		
My Child's First Name		
ON SOCIAL MEDIA	**I DO**	**I DO NOT**
Photographs		
Written Testimonials		
Video Testimonials		
My Profile Name		

Power Chiropractic is happy to celebrate and display written testimonials, photographs, and videos in our office and on our social media outlets to educate others about the benefits of chiropractic.

Place an "X" in the boxes to the left to select your preferences.

- **Selecting I DO authorizes Power Chiropractic to display the item.**
- **Selecting I DO NOT does not authorize Power Chiropractic to display the item.**

_____

Attending Doctor's Signature Date