Harmony
Family Chiropractic

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OFFICE USE ONLY
ID #_____
Date: / /

Pediatric Intake Paperwork

HELLO AND WELCOME TO HARMONY!

Who may we thank for referring you / how did you hear about us? _____

Please fill out the following information completely and to the best of your ability.
Sign the bottom of each page please.

Personal Information

Child's First Name: _____ Last Name: _____

Preferred name: _____ DOB: ___/___/___ Age: _____

Gender: ☐ M ☐ F Child's SSN: ___-___-___ Height: ___ft___in Weight: _____lbs

Hobbies: _____

Parent/Guardian Name(s): _____ _____

Email: _____ _____

Cell Phone: _____ _____

Work Phone: _____ _____

Parent/Guardian financially responsibly for child's: Name: _____ SSN: ___-___-___

Street Address: _____ Apt.Unit#: _____

City/State/Zip: _____

Emergency Contact

Name: _____ Cell Phone: _____ Relation: _____

Who is your child's pediatrician? _____ Date of last visit: ___/___/___

May we contact them about your child's care in our office? ☐ Yes ☐ No

Reason for last doctor visit: _____

Is your child receiving care from any other health professionals? ☐ No ☐ Yes (if yes please list them by name and specialty)

Name: _____ Specialty: _____

Name: _____ Specialty: _____

Name: _____ Specialty: _____

Please note any significant family medical history: _____

Do you have any health concerns for other family members today? _____

Chiropractic History

What would you like to gain from chiropractic care for your child?

❑ Resolve existing challenge ❑ Overall wellness + prevention ❑ Both

Has your child received chiropractic care in the past? ❑ No ❑ Yes, as an ❑ Infant ❑ Child ❑ Teen

If yes, what is their name(s)? _____

What is their specialty? ❑ Pain Relief ❑ Nutritional ❑ Physical Therapy & Rehab ❑ Subluxation-based ❑ Other

If other specialty, specify? _____

Drugs/Medications/Vitamins/Herbs

Is your child taking any drugs/ medications/ vitamins/ supplement or natural remedy? ❑ No ❑ Yes,

	Medication Name	Dosage	Frequency	Reason for Taking
1				
2				
3				

Current Health Conditions

What are the primary health concerns for your child? _____

Please describe when your child's issues first began and how they've progressed since: _____

What makes things better? _____

What makes things worse? _____

Health Goals For Your Child

What are your top three health goals for your child?

1. _____

2. _____

3. _____

Many types of stressors (physical, mental, chemical) can interfere with your child's growing brain, spine, and nervous system. To serve them better, please complete the following information
We look forward to working with you to build better health for your family.

Signature: _____

Pregnancy + Fertility History

Please tell us about your pregnancy.

Any fertility challenges? ❑ No ❑ Yes *(If yes, explain)* _____

Did mother smoke? ❑ No ❑ Yes *(If yes, how many per week)* _____

Did mother drink? ❑ No ❑ Yes *(If yes, how many per week)* _____

Did mother exercise? ❑ No ❑ Yes *(If yes, what type)* _____

Was mother ill? ❑ No ❑ Yes*(If yes, explain)* _____

Any ultrasounds? ❑ No ❑ Yes

Please explain any other concerns or notable episodes of emotional or physical stress during your pregnancy:

Please explain any other concerns or notable remarks about your child's conception or pregnancy:

Labor + Delivery History

Child's birth was: ❑ Vaginal ❑ VBAC ❑ Planned Cesarean ❑ Emergency Cesarean

At how many weeks of pregnancy was your child born? _____ wks

Child's birth was at: ❑ Home ❑ Hospital ❑ Birthing Center ❑ Other: _____

Name of the ❑Doctor/ ❑Midwife? _____

Please select any applicable interventions or complications:

❑ Breech	❑ Induction	❑ Pain meds	If other, specify: _____
❑ Manual assistance	❑ Epidural	❑ Episiotomy	_____
❑ Vacuum extraction	❑ Forceps	❑ Cord wrapped	

Please explain any other concerns or notable remarks about your child's labor and/or delivery:

Birth Weight: _____ Birth Height: _____ APGAR score at birth: _____ APGAR score at 5 minutes: _____

Growth + Development History

Was you child breastfed? ❑ No ❑ Yes *(If yes, how long?)* _____

Difficulty with breastfeeding? ❑ No ❑ Yes *(If yes, is there a certain side that is more difficult for them?)* _____

Did they ever use formula? ❑ No ❑ Yes*(If yes, what age?)* _____

Did/does your child suffer from colic, refulx, skin issues, or constipation as an infant? ❑ No ❑ Yes *(If yes, explain)*

Did/does your child frequently arch their neck/back, feel stiff, or bang their head? ❑ No ❑ Yes *(If yes, explain)*

Signature: _____

At what age did your child:

	Age
Respond to sound:	
Follow an object:	
Hold their head up:	
Vocalize:	
Teething:	
Sit alone:	
Crawl:	
Walk:	
Begin cow's milk:	
Begin solid foods:	

Please list any food intolerances or allergies, and when they began:

	Food intolerance / Allergy	When they began
1		
2		
3		

Please list your child's hospitalizations and surgical history, including the year:

	Hospitalization / Surgery	Year
1		
2		
3		

Please list any major injuries, accidents, falls and/or fractures your child has sustained in his/her lifetime, including the year:

	Injury	Year
1		
2		
3		

Have you chosen to vaccinate your child? ❑ No ❑ Yes, on a delayed schedule ❑ Yes, on schedule *(If yes, explain any reactions)*

Has your child received any antibiotics? ❑ No ❑ Yes *(If yes, how many times and list reason)*

Any difficulty with bonding or social development? ❑ No ❑ Yes *(If yes, please explain)*

Does your child have night terrors or difficulty sleeping? ❑ No ❑ Yes *(If yes, please explain)*

Does your child have any behavioral, social, or emotional issues? ❑ No ❑ Yes *(If yes, please explain)*

How many hours a day does your child typically spend watching a TV, computer, tablet, or phone?_____ hours
How would you describe your child's diet? ❑ Mostly whole, organic foods ❑Pretty average ❑High amount of processed foods

Are there other health concerns, or is there anything else you'd like us to know about your child?

Signature:_____

Review of Systems

DIRECTIONS: Check the box(es) that apply to conditions that your child/your child's family members currently suffer from/have suffered from in the past. (Was your child Adopted? ❑ No ❑ Yes)

Condition	*Past*	Present
Colic & Excessive Crying	❑	❑
Difficulty Latching / Nursing	❑	❑
Reflux & Excessive Spit Up	❑	❑
Projectile Vomiting	❑	❑
Frequent Stiffening, Rigidity, Arching	❑	❑
Difficulty Sleeping	❑	❑
Torticollis	❑	❑
Plagiocephaly	❑	❑
Motor Milestone Delays	❑	❑
Low Tone & Coordination Challenges	❑	❑
Speech & Communication Delays	❑	❑
Sensory Processing Challenges	❑	❑
Social / Emotional Challenges	❑	❑
Frequent Tantrums & Meltdowns	❑	❑
Behavior Issues	❑	❑
Hyperactivity & Impulsivity	❑	❑
Anxiety & Emotional Instability	❑	❑
ADHD / ADD	❑	❑
Balance & Coordination Issues	❑	❑
Visual & Auditory Processing Challenges	❑	❑
Handwriting & Fine Motor Challenges	❑	❑
Low Energy and Fatigue	❑	❑
Depression & Lack of Confidence	❑	❑
Lightheadedness & Dizziness	❑	❑
Frequent Naseau & Malaise	❑	❑
Headaches & Migraines	❑	❑
Stick Neck & Shoulders	❑	❑
Jaw, Swallowing, Sensory Food Aversions	❑	❑
Vision & Hearing Issues	❑	❑
Ear & Sinus Infections	❑	❑
Sore Throat and Strep	❑	❑

	Past	Present
Strep & Upper Respiratory Infections	❑	❑
Allergies and Autoimmune Challenges	❑	❑
Chronic Inflammation	❑	❑
Poor Metabolism & Weight Control	❑	❑
Chronic Chest Colds & Cough	❑	❑
Bronchitis & Pneumonia	❑	❑
Asthma	❑	❑
Blood Sugar Problems	❑	❑
Skin Conditions / Rash	❑	❑
Ulcerative Colitis, Crohn's, IBS	❑	❑
Kidney Challenges	❑	❑
Gas Pain & Bloating	❑	❑
Gluten & Casein Intolerance	❑	❑
Constipation	❑	❑
Bladder & Urination Issues	❑	❑
Hormonal Challenges	❑	❑
Low Back Pain & Stiffness	❑	❑
Lumbopelvic / SI Joint Pain	❑	❑
Tight Hamstrings & Calves	❑	❑
Toe Walking	❑	❑
Poor Circulation & Cold Feet	❑	❑
Weak Ankles & Arches	❑	❑

Signature _____ Date _____

Child's Name: _____ Date: _____

TERMS OF ACCEPTANCE

Please read the below and if you have any questions, feel free to ask one of our staff members

Harmony Family Chiropractic Notice of Privacy Policy

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your Personal Health Information. In addition we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or as dictated by our office policy, we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. In addition, you will find we have placed several copies in report folders labeled 'HIPAA' on tables in the reception. Once you have read this notice, please sign the last page, and return only the signature page (page 2) to our front desk receptionist. **Keep this page for your records.**

PERMITTED DISCLOSURES:

1. Treatment purposes – discussion with other health care providers involved in your care.
2. Inadvertent disclosures – open treating area mean open discussion. If you need to speak privately to the doctor, please let our staff know so we can place you in a private consultation room.
3. For payment purposes – to obtain payment from your insurance company or any other collateral source.
4. For workers compensation purposes – to process a claim or aid in investigation.
5. Emergency – in the event of a medical emergency we may notify a family member.
6. For Public health and safety – in order to prevent or lessen a serious or eminent threat to the health or safety of a person or general public.
7. To Government agencies or Law enforcement – to identify or locate a suspect, fugitive, material witness or missing person.
8. For military, national security, prisoner and government benefits purposes.
9. Deceased persons – discussion with coroners and medical examiners in the event of a patient's death.
10. Telephone calls or emails and appointment reminders – we may call your home and leave messages regarding a missed appointment or apprize you of changes in practice hours or upcoming events.
11. Change of ownership- in the event this practice is sold, the new owners would have access to your PHI.

YOUR RIGHTS:

1. To receive an accounting of disclosures.
2. To receive a paper copy of the comprehensive "Detail" Privacy Notice.
3. To request mailings to an address different than residence.
4. To request Restrictions on certain uses and disclosures and with whom we release information to, although we are not required to comply. If, however, we agree, the restriction will be in place until written notice of your intent to remove the restriction.
5. To inspect your records and receive one copy of your records at no charge, with notice in advance.
6. To request amendments to information. However, like restrictions, we are not required to agree to them.
7. To obtain one copy of your records at no charge, when timely notice is provided (72 hours). X-rays are original records and you are therefore not entitled to them. The fee for copying your x-rays on a disc is $15.00. This fee must be paid in advance.

COMPLAINTS:

If you wish to make a formal complaint about how we handle your health information, please call Harmony Family Chiropractic at (919) 234-0505. If Dr. Jaylene Bair and/or Dr. Christopher Hopkins are unavailable, you may make an appointment with our team to see him/her within 72 hours or 3 working days. If you are still not satisfied with the manner in which this office handles your complaint, you can submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Ave. SW
Room 509F HHH Building
Washington DC 20201

If you would like a copy please request one from the front desk

Harmony Family Chiropractic Notice of Privacy Policy (Continued)

I have received a copy of Harmony Family Chiropractic Patient Privacy Notice. I understand my rights as well as the practice's duty to protect my health information, and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this "Notice of Privacy Practice" at a time in the future and will make the new provisions effective for all information that it maintains past and present.

I am aware that a more comprehensive version of this "Notice" is available to me and several copies kept in the reception area. At this time, I do not have any questions regarding my rights or any of the information I have received.

Patient Name: _____ **Date of Birth:** _____

Guardian Signature: _____ **Date:** _____

Informed Consent

A patient, in coming to the chiropractic doctor, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or care if he/she is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known, or to learn through healthcare procedures what he/she is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the chiropractic physician. The chiropractic doctor provides a specialized, non-duplicating health care service. Your child's doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regimen. I understand that if my child is accepted as a patient by a physician at Harmony Family Chiropractic, I am authorizing them to proceed with any treatment that they deem necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

Guardian Signature: _____ **Date:** _____

Authorization for X-ray

X-rays are utilized in the office to help locate and analyze vertebral subluxations. These x-rays are not to be used to investigate for medical pathology. The doctors of Harmony Family Chiropractic do not diagnose or treat medical conditions; however if any abnormalities are found, they will be brought to your attention so that you can seek proper medical advice. By my signature below I am acknowledging that the doctor and/or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

At your request, we will provide you with a copy of your x-rays in our file. The fee for copying your x-rays on a disc is $15.00. This fee must be paid in advance. Digital x-rays on CD will be available within 72 hours of prepayment on any regular practice hours day. Please note: x-rays are utilized in this office to help locate and analyze vertebral subluxations.

Guardian Signature: _____ **Date:** _____

(*Females Only*) Please check the box that applies to your child - To the best of your knowledge:

- ❑ My child is NOT pregnant at this time
- ❑ My child IS/ I believe my child MAY BE pregnant, therefore I DO <u>NOT</u> authorize Harmony Family Chiropractic to X-ray me at this time.
- ❑ The first day of my last menstrual cycle was on ___-___-___ (Date)

Guardian Signature: _____ **Date:** _____

Authorization for Release of Health Information

I authorize Harmony Family Chiropractic to release all necessary information concerning my health condition to my billing company, insurance company, attorney, and/or adjuster in order to process any claim for reimbursement of charges incurred by me. In addition, I authorize Harmony Family Chiropractic to release any information regarding my health condition to other health care providers involved in my 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 Harmony Family Chiropractic to proceed with chiropractic tests, diagnosis, analysis, and adjustments.

Guardian Signature: _____ **Date:** _____

Photo and Social Media Consent

We love to have kid's pictures in our office! If you would allow us to have your child's picture in the office, please sign below.

For valuable consideration, I herby irrevocably consent to and authorize the use and reproduction by Harmony Family Chiropractic, or anyone authorized by Harmony Family Chiropractic, of any and all photographs/videos which were taken of my child, for the purpose of promotional TV, website, social media and/or print as whatsoever, withoutfurther compensation to me. All negative and positives, together with theprints shall constitute the property of Harmony Family Chiropractic, solely and completely. Any information voluntarily provided by a patientpatient, including first name, shall also be used in conjunction with the above listed information for the purposes previously mentioned. Confidentially, in regards to any reported conditions, is also waived to the extent of information pertinent to the promotion material only. I authorize Harmony Family Chiropractic, to share this information via their website and their Facebook/social media including Twitter and Instagram, and for use in the office. All other unrelated patient information shall remain private and protected (according to Health Information and Privacy Act laws). Do not sign if you would like for photos not to be taken. Thank you

Guardian Signature: _____ **Date:** _____

We also encourage you take take photos and share them on social media. We love seeing them!

Cancellation/ Broken Appointment Policy

Our commitment to your great chiropractic care begins with a defined schedule in which we have allotted specific amounts of time for you and other patient abased on your specific needs. With said, we understand that "life" happens and results in needed changes to our day to day schedule that may prevent us from keeping an appointment. We respectfully request at least 12 hour advanced notice if you need to cancel an appointment. Giving us as much notice as possible ensures that someone else is able to take advantage of the time that was allotted to you.

An appointment that is cancelled with less than 12 hours' notice or an appointment that is not canceled at all in which the patient fails to appear to is considered a broken appointment. Broken appointments delay the success of your treatment and the treatment of other patients. Therefore, any broken appointments will result in a $25.00 office fee.

Thank you in advanced for your compliance without cancellation and broken appointment policies. Please know that all policies are in place to ensure a great chiropractic experience for you and your family. Again, we look forward to serving your every chiropractic need!

Please initial below that you read and understand the cancellation and broken appointment policy.

Guardian Signature: _____ **Date:** _____