OFFICE USE ONLY
ID#: _____

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PEDIATRIC INTAKE

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. Initial the bottom of every page.

PERSONAL INFORMATION

FIRST NAME: _____ LAST NAME: _____ PREFERRED NAME: _____

DOB: ____/_____/_____ AGE: _____ HEIGHT: _____ WEIGHT:_____lbs GENDER: ❑M ❑F SSN: _____-_____-_____

STREET ADDRESS: _____ APT/UNIT: _____ CITY/STATE/ZIP: _____

PARENT/GUARDIAN NAME(s) **1.** _____ EMAIL:_____ PHONE:_____

2. _____ EMAIL:_____ PHONE:_____

PARENT/GUARDIAN FINANCIALLY RESPONSIBLE FOR CHILD : **#1** **#2** **both** HOBBIES: _____

CHILD'S PEDIATRICIAN: _____ DATE OF LAST VISIT: _____/_____/_____ REASON: _____

MAY WE CONTACT THEM ABOUT YOUR CHILD'S CARE IN OUR OFFICE? ❑No ❑Yes

PLEASE NOTE ANY SIGNIFICANT FAMILY MEDICAL HISTORY: _____

EMERGENCY CONTACT | name: _____ phone: _____ relation:_____

CURRENT HEALTH PROBLEM

PURPOSE OF THIS VISIT: ❑WELLNESS CARE ❑HEALTH CONCERN ❑OTHER:_____

WHAT IS THE **PRIMARY HEALTH CONCERN** FOR YOUR CHILD AND IF APPLICABLE DESCRIBE WHERE AND FOR HOW LONG:

_____

When did the problem first begin? **Date**: ____-____-____ ❑Unknown ❑Gradual ❑Sudden Was the issue caused by ANY type of accident ❑No❑Yes

Any bowel or bladder problems since this problem began? ❑No ❑Yes Does the problem RADIATE or travel outward? ❑No ❑Yes

Has this problem occurred before? ❑No ❑Yes If yes, when? _____

Have you seen any other doctor for this problem? ❑No ❑Yes If yes, when? _____ by whom? _____

How long were you under care? _____ What were the results? _____

What makes it better? _____ What makes it worse? _____

How is this problem NOW? ❑Rapidly Improving ❑Improving Slowly ❑About the Same ❑Gradually Worsening ❑On and Off

Please list any medication(s) taken for this problem: _____

Are there any SECONDARY health concerns you wish to bring to our attention? _____

Has your child ever sustained an injury playing organized sports? ❑No ❑Yes If yes, explain:_____
Has your child ever sustained an injury in an auto accident? ❑No ❑Yes If yes, explain:_____
Has your child received chiropractic care in the past? ❑No ❑Yes If yes, name of previous chiropractor: _____
Any other hereditary conditions the doctor should be aware of? ❑No ❑Yes , _____

MEDICATIONS (PRESCRIBED and OVER-THE-COUNTER / VITAMINS / SUPPLEMENTS	
NAME	**REASON FOR TAKING**

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PREGNANCY + FERTILITY HISTORY

Any fertility challenges? ❑No ❑Yes If yes, explain:_____ Number of ultrasounds? _____

Did mother smoke? ❑No ❑Yes; how many per week? _____ Did mother drink? ❑No ❑Yes; how many per week? _____

Did mother exercise? ❑No ❑Yes; explain type :_____ Was mother ill? ❑No ❑Yes; explain:_____

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?____

Child's birth was at: ❑ Home ❑ Hospital ❑ Birthing Center ❑ Other:_____ Name of the ❑Doctor/ ❑Midwife?_____

Please select any applicable interventions or complications: ❑Breech ❑Manual assistance ❑Vacuum extraction ❑Induction

❑Epidural ❑Forceps ❑Pain meds ❑Episiotomy ❑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: _____

LABOR + DELIVERY HISTORY

Was your child breastfed? ❑No ❑Yes; for how long? _____ Did they ever use formula? ❑ No ❑ Yes; what age? _____

Difficulties with breastfeeding? ❑No ❑Yes (If yes, is there a certain side that is more difficult for them?) ❑Left ❑Right

Did/does your child suffer from colic, reflux, skin issues, or constipation as an infant? ❑No ❑Yes; explain:_____

Did/does your child frequently arch their neck/back, feel stiff, or bang their head? ❑No ❑Yes; explain:_____

MILESTONES – AT WHAT AGE DID YOUR CHILD…?

_____ Respond to Sound	_____ Vocalize	_____ Crawl
_____ Follow an object	_____ Teething	_____ Walk unassisted
_____ Hold their head up	_____ Sit alone	_____ Begin cow milk

PLEASE LIST ANY FOOD INTOLERANCES OR ALLERGIES, AND WHEN THEY BEGAN:

FOOD INTOLERANCE / ALLERGY	WHEN THEY BEGAN

PLEASE LIST YOUR CHILD'S HOSPITALIZATIONS AND SURGICAL HISTORY, INCLUDING THE YEAR:

HOSPITALIZATION / SURGERY	YEAR

PLEASE LIST ANY MAJOR INJURIES, ACCIDENTS, FALLS AND/OR FRACTURES YOUR CHILD HAS SUSTAINED IN HIS/HER LIFETIME

INJURY	YEAR

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Has your child been vaccinated? ❑No ❑Yes, on a delayed schedule ❑ Yes, on schedule Any reactions?_____

Has your child received any antibiotics? ❑No ❑Yes; how many times and reason:_____

Any difficulty with bonding or social development? ❑No ❑Yes, explain:_____

Does your child have night terrors or difficulty sleeping? ❑No ❑Yes explain:_____

Does your child have any behavioral, social, or emotional issues? ❑No ❑Yes explain:_____

How many hours a day does your child typically spend watching a TV, computer, tablet, or phone? _____

How would you describe your child's diet? ❑ Mostly whole, organic foods ❑Pretty average ❑High amount of processed foods ❑Dairy ❑Sugar

ANY 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

HAS YOUR CHILD EVER SUFFERED FROM – check all that apply

- O Colic & Excessive Crying
- O Difficulty Latching / Nursing
- O Reflux & Excessive Spit Up
- O Projectile Vomiting
- O Frequent Stiffening, Rigidity, Arching
- O Difficulty Sleeping
- O Torticollis
- O Plagiocephaly
- O Motor Milestone Delays
- O Low Tone & Coordination Challenges
- O Speech & Communication Delays
- O Sensory Processing Challenges
- O Blood Sugar Problems
- O Skin Conditions / Rash
- O Ulcerative Colitis, Crohn's, IBS
- O Kidney Challenges
- O Gas Pain & Bloating
- O Gluten & Casein Intolerance
- O Poor Posture
- O Social / Emotional Challenges
- O Frequent Tantrums & Meltdowns
- O Behavior Issues
- O Hyperactivity & Impulsivity
- O Anxiety & Emotional Instability
- O ADHD / ADD
- O Balance & Coordination Issues
- O Visual & Auditory Processing Challenges
- O Handwriting & Fine Motor Challenges
- O Low Energy and Fatigue
- O Depression & Lack of Confidence
- O Lightheadedness & Dizziness
- O Frequent Nausea & Malaise
- O Heart Trouble
- O Constipation
- O Bladder & Urination Issues
- O Hormonal Challenges
- O Low Back Pain & Stiffness
- O Lumbopelvic / SI Joint Pain
- O Headaches & Migraines
- O Stick Neck & Shoulders
- O Jaw, Swallowing, Sensory Food Aversions
- O Vision & Hearing Issues
- O Ear & Sinus Infections
- O Sore Throat and Strep
- O Strep & Upper Respiratory Infections
- O Allergies and Autoimmune Challenges
- O Chronic Inflammation
- O Poor Metabolism & Weight Control
- O Chronic Chest Colds & Cough
- O Bronchitis & Pneumonia
- O Asthma
- O Tight Hamstrings & Calves
- O Toe Walking
- O Poor Circulation & Cold Feet
- O Weak Ankles & Arches
- O Seizures/Convulsions
- O Bedwetting

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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

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: _____ DOB: _____/_____/_____

_____	_____	_____ - _____ - _____
Print Guardian Legal Name	**Patient or Authorized Person's Signature**	**Date Completed**

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. In the event that there are findings considered to be abnormal, your films will be sent to a board certified chiropractic radiologist. If it is necessary to submit your films you will be responsible for the charges. The charge will be no greater than **$25.00**. You will be notified of abnormal findings prior to your films being sent.

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

- ❏ MY CHILD IS NOT pregnant at this time
  - ❏ The first day of your child's last menstrual cycle was on ____-____-____ (Date)
- ❏ MY CHILD MAY BE pregnant, therefore I DO NOT authorize Harmony Family Chiropractic to X-ray me at this time.

Guardian or Authorized Person's Signature _____ **Date Completed** _____ - _____ - _____

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. In addition, I authorize Harmony Family Chiropractic to disclose all necessary information to individuals I permit to accompany me during my visits. It is my responsibility to not allow individuals to accompany me in the event I do not want information disclosed to them. 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 or Authorized Person's Signature _____ **Date Completed** _____ - _____ - _____

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 hereby 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, without further compensation to me. All negative and positives, together with the prints shall constitute the property of Harmony Family Chiropractic, solely and completely. Any information voluntarily provided by a patient, 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 or Authorized Person's Signature _____ **Date Completed** _____ - _____ - _____

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

HEALING HAPPENS HERE

INFORMED CONSENT

We encourage and support a shared decision making process between us regarding your health needs. As a part of that process you have a right to be informed about the condition of your health and the recommended care and treatment to be provided to you so that you can make the decision whether or not to undergo such care with full knowledge of the known risks. This information is intended to make you better informed so that you can knowledgeably give or withhold your consent.

Chiropractic is based on the science which concerns itself with the relationship between structures (primarily the spine) and function (primarily of the nervous system) and how this relationship can affect the restoration and preservation of health.

Adjustments are made by chiropractors in order to correct or reduce spinal and extremity joint subluxations. Vertebral subluxation is a disturbance to the nervous system and is a condition where on or more vertebra in the spine is misaligned and/or does not move properly causing interference and/or irritation to the nervous system. The primary foal in chiropractic care is the removal and/or reduction of nerve interference caused by vertebral subluxation.

A chiropractic examination will be performed which may include spinal and physical examination, orthopedic, and neurological testing, palpation, specialized instrumentation, radiological examination (x-rays), and/ or laboratory testing.

The chiropractic adjustment is the application of a precise movement and/or force into the spine in order to reduce or correct vertebral subluxation(s). There are a number of different methods or techniques by which the chiropractic adjustment is delivered but are typically delivered by hand. Some may require the use of an instrument or other specialized equipment. In addition, physiotherapy or rehabilitative procedures may be included in the management protocol. Among other things, chiropractic care may reduce pain, increase mobility, and improve quality of life.

In addition to the benefits of chiropractic care and treatment, one should also be aware for the existence of some risks and limitations of this care. The risks are seldom high enough to contraindicate care and all health care procedures have some risk associated with them.

Risks associated with some chiropractic treatment may include soreness, musculoskeletal sprain/strain, and fracture.

I have been informed of the nature and purpose of chiropractic care, the possible consequences of care, and the risks of care, including the risk that the care may not accomplish the desired objective. Reasonable alternative treatments have been explained, including the risks, consequences and probable effectiveness of each. I have been advised of the possible consequences if no care is received. I acknowledge that no guarantees have been made to me concerning the results of the care and treatment.

I have read the above paragraphs. I understand the information provided. all questions I have about this information have been answered to my satisfaction. Having this knowledge, I knowingly authorize Harmony Family Chiropractic to proceed with chiropractic care.

Parental Consent for Minor Patient:

Patient name: _____ DOB: _____/_____/_____

Name of person legally authorized to sign for patient: _____ Relationship to patient: _____

Guardian or Authorized Person's Signature _____ **Date Completed** _____ - _____ - _____

DOCTORS SIGNATURE_____

In addition, by signing below, I give permission for the above named minor patient to be managed by the doctor even when I am not present to observe such care. ONLY AUTHORIZED FOR THOSE 16 YEARS OF AGE OR OLDER.

Guardian or Authorized Person's Signature _____ **Date Completed** _____ - _____ - _____