PEDIATRIC INTAKE FORM

File: ________________

PERSONAL INFORMATION

Date: ____________________________

First Name: __________________________M.I.: ______Last Name: __________________________

Preferred Name: ________________________

Birth Date: ____________________________ Age: ______________ Sex : M F

Address: ____

City / State / Zip : ____ Native Language: ____________

Cell Phone : (______) ___________________ Alternative Phone (______) __________________

Text Reminders: Y N Before Appointment: 1 hr 4 hr 1 day Phone Carrier: ______________

Email: ____ *(For updates on office hours, events and emergencies, ect.)*

# of Siblings ____________ Do you have insurance? Y N Company _______________

Who can we thank for referring you or how did you hear about Rubinstein Family Chiropractic?

REASON FOR SEEKING CARE

What is your reason for seeking care? (circle) PAIN WELLNESS OTHER _______________

When did this begin? (If applicable) ____

Has your child had any injuries/hospitalizations/car accidents and/or surgeries? (circle) No

Yes:____

What is this affecting that is MOST important in your child's life? *Sleeping Standing Sitting*

*Dressing Walking School Work Social Skills Quality of life Other:*____________________

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

____

Has your child seen a chiropractor before? Yes No How long ago?__________________________

What health goal, for your child would have the greatest impact on their life?

____

Does your child have any behavioral problems or child parent bonding concerns? (circle) Yes No

Do you feel your child's social and emotional development is normal for their age? (circle) Yes No

Any additional reasons for seeking care? :____

HEALTH CONCERNS

DID YOU KNOW…

Each health concern relates to a specific area of the spine and nervous system?

- ☐ Anxiety/Depression
- ☐ Digestive Trouble
- ☐ Nausea/Vomiting
- ☐ Diabetes
- ☐ Bed Wetting
- ☐ Frequent Sickness
- ☐ ADD/ADHD
- ☐ Neck/Back Pain
- ☐ Headaches
- ☐ Irritability/ Nervous
- ☐ Fatigue/Sleep Issues
- ☐ Colic/Acid Reflux
- ☐ Dizziness
- ☐ Asthma/ Breathing
- ☐ Memory Problems
- ☐ Headaches
- ☐ Ear or Other Infections
- ☐ Sinus Trouble /Allergies
- ☐ Learning Disorders
- ☐ Autism/ Asperger's / Sensory Issues
- ☐ Other:___________

Is there anything else regarding your current condition you think we should know? Circle) Yes No

Explain:____

Does your child have a family history of health problems? Yes No Explain: ____________________

Does your child have any allergies or intolerances? Yes No Explain: __________________________

Has your child been vaccinated? Yes No If yes: Recommended Schedule Alternative Schedule

Has your child ever taken antibiotics? Yes No If yes: # of doses_________ last date___________

Has your child had any adverse reactions to any medications or vaccinations? Yes No

Explain____

MEDICATIONS

- ☐ Asthma
- ☐ Pain Narcotics
- ☐ Antibiotics
- ☐ Acid Reflux
- ☐ ADD/ADHD
- ☐ Diabetes
- ☐ ______________
- ☐ _____________
- ☐ _____________

VITAMINS

- ☐ Multi-Vitamin
- ☐ Calcium
- ☐ Fish Oil
- ☐ Probiotics
- ☐ Melatonin
- ☐ _____________
- ☐ _____________
- ☐ _____________
- ☐ _____________

THERAPY

- ☐ None
- ☐ Speech Therapy Current Past
- ☐ Occupational Therapy Current Past
- ☐ Physical Therapy Current Past
- ☐ Behavioral Current Current Past
- ☐ _____________ Current Past

EMERGENCY CONTACT

Name:___________________________________

Relationship: ______________________________

Phone: _________________________________

PRENATAL HISTORY

Did MOM have any complications/traumas or illness during pregnancy? Yes No If Yes:____________

Did MOM have any ultrasounds during pregnancy? Yes No If Yes how many?:___________________

During pregnancy did MOM take any: (circle) *Vitamins* *Prescription Medication* *Alcohol*

Over the Counter Medication *Recreational Drugs* *Alcohol* *Smoking*

Did MOM have any special tests during pregnancy? Yes No If Yes:_____________________

Location of birth: (circle) *Home* *Birthing Center* *Hospital* Other: ___________________________

Did any of the following happen during the delivery: *Circle all that apply*

C-section *Doctor/Attendant pulled or twisted the baby* *Epidural* *Anesthesia*

Labor Induction *Forceps/Vacuum* *Premature delivery* *Other Birth trauma*

Describe any of the above or any additional complications during delivery: __________________________

Gestation age_____ weeks Birth weight: _______ Birth Length _______ APGAR score __________

Did the baby have breastmilk? Yes No If yes, how long: ____________________________________

Did the baby have formula? Yes No If yes, how long: ______________ Type: Dairy Soy

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

CURRENT LIFESTYLE

Does your child…

- Exercise daily or play sports? Yes No How much? __________________Type: ____________
- Watch TV / play video games / tablet ? Yes No How many hours: 0-5 5-10 10-15 15+
- Eat well balanced meals? Yes No Explain:___________________________
- Have difficulty sleeping? Yes No Explain:________________________________
- Does your child wear a backpack? Yes No If yes is it heavy or light? ___________________

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, ect.). *Was this the case for your child?* **Yes No**

- Is/ has your child ever been involved in any high impact sports (soccer, football, martial arts, cheerleading/parkour)? Yes No Type: ________________

<u>Please rate stress levels on a scale of 1-10 (10 being the highest)</u>

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

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

HEALTH CARE AUTHORIZATION FORM

I have been provided with a copy of the Notice of Privacy Practices for Protected Health Information. The Notice of Privacy Practices describes the types of uses and disclosures of my Protected Health Information (PHI) that will occur in my treatment, payment of my bills or in the performance of health care operations of this chiropractic office. A copy of our notice is provided and we encourage you to read it and request your own copy if you would like one.

This Notice of Privacy Practices also describes my rights and duties of the Chiropractor with respect to my protected health information. I hereby give permission to Rubinstein Family Chiropractic Center to use and/or disclose Protected Health Information in accordance with the following:

SPECIFIC AUTHORIZATIONS:

I give permission to Rubinstein Family Chiropractic to use my address, phone number and clinical records to contact me with appointment reminders, missed appointment notification, birthday cards, holiday related cards, newsletters, information about treatment alternatives or other health related information.

If Rubinstein Family Chiropractic contacts me by phone, I give them permission to leave a phone message on my answering machine or voice mail.

I give permission to Rubinstein Family Chiropractic to use my name on a welcome board, referral board, and birthday board.

I give permission to Rubinstein Family Chiropractic to use my photograph on their patient picture bulletin board and other marketing materials such as their brochure, website and ads in print media.

I give permission to Rubinstein Family Chiropractic to use any testimonial written by me for marketing purposes such as, sharing with other patients or potential patients, in their brochure, on their website or in ads in print media.

I give Rubinstein Family Chiropractic permission to treat me in an open room where other patients are also being treated. I am aware that other persons in the office may overhear some of my protected health information during the course of care. Should I need to speak with doctor at any time in private, the doctor will provide a room for these conversations.

By signing this form you are giving Rubinstein Family Chiropractic permission to use and disclose your protected health information in accordance with the directives listed above.

The use of this format is intended to make your experience with our office more efficient and productive as well as to enhance your access to quality health care and health information. This authorization will remain in effect for the duration of my care at Rubinstein Family Chiropractic plus 7 years or until revoked by me.

RIGHT TO REVOKE AUTHORIZATION:

You have the right to revoke this AUTHORIZATION, in writing, at any time. However, your written request to revoke this AUTHORIZATION is not effective to the extent that we have provided services or taken action in reliance on your authorization.

You may revoke this AUTHORIZATION by mailing or hand delivering a written notice to the Privacy Official of Rubinstein Family Chiropractic. The written notice must contain the following information:

Your name, Social Security number and date of birth;
A clear statement of your intent to revoke this AUTHORIZATION;
The date of your request; and
Your signature.

The revocation is not effective until it is received by the Privacy Official.
This AUTHORIZATION is requested by Rubinstein Family Chiropractic for its own use/disclosure of PHI. *(Minimum necessary standards apply.)*
I have the right to refuse to sign this AUTHORIZATION. If I refuse to sign this AUTHORIZATION, Rubinstein Family Chiropractic will not refuse to provide treatment however, it will not be possible for Rubinstein Family Chiropractic to file third party billing on my behalf and I will be responsible for 1)payment in full at the time services are provided to me 2) scheduling my own appointments since Rubinstein Family Chiropractic will be unable to contact me 3) all contact with Rubinstein Family Chiropractic regarding my care. *Additionally, any collection activity as permitted by law is not waived by refusal to sign the authorization.* I have the right to inspect or copy, within boundaries, the protected health information to be used/disclosed. A reasonable fee for copying will apply. A copy of the signed authorization will be provided to me.

HEALTH CARE AUTHORIZATION FORM CONTINUED

HEALTHCARE AUTHORIZATION

I have read and understand this Healthcare Authorization Form and acknowledge receipt of The Notice of Privacy Practices for Protected Health Information. My signature below represents agreement with these practices.

Patient's name (please print): ______________________________________

Name of Personal Representative (if someone is designated to act on your behalf/or for a minor)

Parent or Personal Representative name (please print):_________________________________

Signature:____Relationship to patient:__________________________

CONSENT TO TREAT MINOR

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.

Signature:____________________________________ Relationship to patient:_________________________

OFFICE AND 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 doctors recommendations for care. Please keep your appointments as scheduled or call the office within 24 hours to make any changes.
- I authorize Rubinstein Family Chiropractic to release any information deemed appropriate concerning my physical condition to any insurance company, attorney, or adjuster in order to process any claims for reimbursement for charges incurred by me.
- Chiropractic care in this office deals with vertebral subluxation, and may be billed under the S8990 adjustment code While we will provide an itemized receipt upon your request, we anticipate that care will not be reimbursed by a third party carrier as this is considered wellness or maintenance care. This does not apply to PI, Medicare or Medicaid. HSA and FLEX spending may still be utilized. This notice is not an official Medicare of other insurance carrier decision.
- I authorize the direct payment to Rubinstein Family Chiropractic of any sum I now or hereafter owe by my attorney out of settlement in my case or by any insurance company obligated to make payment to me or Rubinstein Family Chiropractic base in whole or part upon charges made for services received.
- If you have an auto accident, a workers compensation injury or other injury that insurance requires direct billing, you will be expected to complete all the paperwork necessary for us to file the claim on your behalf.
- If you need to make special arraignments, please ask. We will do our best to accommodate your financial needs.
- I understand that I will be responsible for fees billed to my or my child/children's account for all services received at the time of service.

I understand that most major medical insurance only covers active complaints and I will be responsible for denied insurance claims considered to be wellness or supportive care.

I understand I am responsible for deductible , copayment or non covered services with payment due to this office at the time of service and additional payment may be required after insurance processes claims.

Account balances over 30 days will be charged to my credit card unless prior arrangements have been made.

We accept MasterCard, Visa, American Express, Cash and Checks in exchange for services.

________________________________ ____________

Signature Date

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 in order 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 one 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 goal 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 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 of 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. Risks associated with physiotherapy may include the preceding as well as allergic reaction and muscle and/or joint pain. In addition there are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke; rather, recent studies indicate that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence, there is a stroke already in process. However, you are being informed of this reported association because a stroke may cause serious neurological impairment.

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 paragraph. I understand the information provided. All questions I have about this information have been answered to my satisfaction. Having this knowledge, I knowingly authorize Rubinstein Family Chiropractic LLC, Dr. J. Shimon Rubinstein DC and/or Dr. Melissa Rubinstein DC to proceed with chiropractic care and treatment.

____________________________________ ____________

Signature (parent if minor) Date