Family Chiropractic
204 Pinehurst Dr. SW #103
Tumwater, WA 98501

Welcome!

Pediatric Chiropractic Intake
Dr. Amanda Kugel

Date _____

Welcome to our office! **The following information is confidential. It will be used to complete your history and understand your condition, so please be as neat and accurate as possible while completing this form. If you have questions about any portion of this form, please ask at the front desk.**

First Name: _____ MI: ____ Last Name: _____
Name of Parent/Guarian: _____
DOB: ____/____/_____ Age: _____ Sex: _____
Address 1: _____ Address 2 : _____
City: _____ State: _____ Zip Code : _____
Primary Phone: _____ Alternate Phone: _____
Personal Email: _____
May we email you with office news and updates: ☐ Yes ☐ No Thanks
Preferred Communication: ☐Phone ☐Mail/Letter ☐Email ☐Patient Portal ☐Fax ☐Decline
Emergency Contact: _____ Relationship to Patient: _____
Phone: _____ Alternate Phone: _____

Describe the reason(s) for this visit today:

_____
_____

Who referred you to us? _____
Who is the Primary Care Provider? _____ Date of last visit _____
Reason for last visit _____
May we update them on this current issue? ☐ Yes ☐ No _____
Have you been to another provider for this issue? ☐ Yes ☐ No
If yes, who? _____ How long ago? _____
May we update them on this current issue? ☐ Yes ☐ No
Prior treatments and outcomes: _____
_____
_____

Past Medical History
Major medical illnesses: _____
Major surgical illnesses-list operations and dates: _____
_____
_____
Previous hospital admissions with dates and diagnoses _____
_____
_____
Current medications, vitamins/supplements, including dosage: _____
_____
Immunization status: ☐ up to date ☐ _____

Pregnancy and Birth History:
Location of Birth and Provider: _____
Complications during pregnancy: ☐ Yes ☐ No List: _____
Ultrasounds during pregnancy ☐ Yes ☐ No Number and reason: _____
Medications during pregnancy/ delivery: ☐ Yes ☐ No List: _____
Cigarette/Alcohol during pregnancy ☐ Yes ☐ No

Birth interventions: ☐ Yes ☐ No (Forceps, Vacuum, Caesarian) briefly explain reason for intervention:

_____

Complication's during delivery☐ Yes ☐ No _____
Birth Weight _____Birth length _____APGAR scores 1min_____ 5min_____
Genetic disorders/ disabilities: ☐ Yes ☐ No List: _____
Feeding problems ☐ Yes ☐ No List: _____

Developmental History

Achieving milestones and developmental abilities☐ Yes ☐ No Hours of sleep per day _____
School: _____present grade_____, specific problems_____
_____,

Interacts with peers	☐ Yes ☐ No	Temper tantrums	☐ Yes ☐ No
Behavior issues	☐ Yes ☐ No	Thumb sucking	☐ Yes ☐ No
Bed wetting	☐ Yes ☐ No	Nightmares	☐ Yes ☐ No

Feeding History:

Breastfed ☐ Yes ☐ No How long? _____ Any difficulties? :_____
Formula fed ☐ Yes ☐ No How Long? _____ Type: _____
Introduced to solids at _____months Problems created _____
Allergies or intolerances ☐ Yes ☐ No List_____

Family History: circle all that apply

Arthritis, Allergy, Asthma, Autism, Autoimmune disorders, Blood disorders, Cancer, Cardiac Disease, Diabetes, Epilepsy, Genetic disorders, Scoliosis, Stroke, Hypertension

Social History

Care providers inside or outside the home:

_____
Family Composition that reside in the same household_____
Number of Siblings: _____ Exposed to second hand smoke ☐ Yes ☐ No How often? _____
Occupation of parents/guardians: _____

Review of Systems: Indicate any current or past issues that have caused concern to seek evaluation.

❑ recent weight changes	❑ draining ears	❑wheezing	❑blood or discharge in urine
❑ rashes	❑colds	❑chronic cough	❑pain with urination
❑ adenopathy	❑ sore throat	❑TB	❑previous infections
❑ lumps	❑tonsillitis	❑constipation	❑fevers
❑ bruising	❑ mouth breathing	❑diarrhea	❑scoliosis
❑ bleeding	❑snoring	❑change in stool color or character	❑joint pain or swelling
❑ pigmentation changes	❑ apnea	❑vomiting	❑weakness
❑ headaches	❑oral thrush	❑jaundice	❑injuries
❑ concussions	❑nosebleeds	❑abdominal pain	❑gait changes
❑ unusual head shape	❑cavities	❑colic	❑hay fever
❑ strabismus (eg.lazy eye)	❑difficulty breathing	❑change in appetite	❑allergic rhinitis
❑ conjunctivitis	❑heart murmurs	❑excessive gas	❑asthma
❑visual problems	❑chest pain	❑excessive spit up	❑ sleep issues
❑ hearing changes	❑palpitations	❑change in urinary frequency	❑eczema
❑ear infections	❑pneumonia		❑drug reactions
	❑bronchiolitis		

Office Policies

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. _____*(Initials)*

We are in network with Regence BS. All other insurances are considered out-of-network. We will bill Regence BS on your behalf, and for all other plans we will provide you with the description of services you received, and you may submit this directly to your insurance company for possible reimbursement if your plan includes out of network benefits. Please know your insurance coverage prior to your visit. All payment is expected at the time of service in the form of debit cards, master card, visa, cash and check. A $30.00 fee will be charged for all returned checks. _____*(Initials)*

In the event that you are not able to keep your scheduled appointment, please give 24 hours' notice prior to canceling. Canceling with less than 24 hours' notice or missing an appointment will result in being charged the cost of the appointment. _____*(Initials)*

NOTICE OF PRIVACY PRACTICE We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your records to get information about it by contacting our office at 360-352-8112. Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed and how you may access your information. _____*(Initials)*

Informed Consent

The doctor of chiropractic evaluates the patient using standard examination and testing procedures. If your history and examination indicate the need you will receive further diagnostic tests or a referral to a specialist. A chiropractic adjustment involves the application of a quick, precise force directed over a very short distance to a specific vertebra or bone. Adjustments are usually performed by hand but may also be performed by hand-guided instruments or equipment. In addition to adjustments, other treatments used by chiropractors include soft-tissue manipulation, nutritional recommendations and exercise. Please list any preferences here_____

The safety profile for chiropractic in children appears to be similar to that in adults, which makes it one of the safest methods of treatment. Most side effects are mild and self-limiting such as muscle soreness. There are some case reports of extremely rare adverse events, but no causal link is established. In fact, for any given condition, chiropractic has a better safety profile than a regularly prescribed or over the counter medication for the same problem.

I have read the previous information regarding risks of chiropractic care and my doctor has verbally explained the risks (if any) and suggested alternatives when those risks exist. I understand the purpose of care and have been given an explanation of the treatment, the frequency of care, and alternatives to this care. All of my questions have been answered to my satisfaction. I agree to this plan of care understanding any perceived risk(s) and alternatives to this care for the above minor patient. By signing I give consent for examination, tests and procedures for the above minor patient. _____*(Initials)*

By signing I have read and understand the Office Policies and Informed Consent:

Print Patient Name: _____

Print Parent/Guardian Name: _____

Parent/Guardian Signature: _____ **Date:** _____