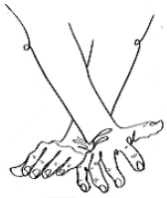
Family Chiropractic
204 Pinehurst Dr. SW #103
Tumwater, WA 98501

Dr. Betsy Burgos Diaz



School-aged child - Adolescent (6-18 y/o)
Chiropractic Intake form

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 accurate as possible while completing this form. If you have any questions about this form, please ask at the front desk.

PATIENT INFORMATION Date ____/____/____

Patient Name _____
LAST FIRST MI

Date of birth _____/_____/_____ Age _____ Height_____ Weight_____lbs. Sex ☐Male ☐Female

Address _____

City _____ State _____ Zip _____

Parent/Guardian Name(s)_____

Cell Phone (_____)_____ Work Phone (_____)_____

Home Phone (_____)_____ Best time to reach you _____

Parent/Guardian email_____

IN CASE OF EMERGENCY, CONTACT

Name _____ Relationship _____

Primary Phone (_____)_____ Secondary Phone (_____)_____

REFERRAL INFORMATION

How did you hear about us? ☐ Facebook ☐ Family/Friend (Whom may we thank for referring you? _____)

☐ Internet Search ☐Primary Physician ☐ Staff ☐ Other _____

Can we send them a thank you note for referring you to us? ☐ Yes ☐ No

AUTHORIZATION FOR CARE OF A MINOR

Parent/Guardian Name_____
I hereby authorize and consent to the chiropractic evaluation and care of my child.

Parent/Guardian Signature:_____ Date ____/____/____

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PATIENT CONDITION

What health condition(s) bring your child to be evaluated by a chiropractor:_____
_____

When did this condition begin?_____/_____/_____ How did the problem start: ☐ Suddenly ☐ Gradually ☐ Post-Injury

How often does your child experience this condition? ☐ Constant ☐ Frequently ☐ Intermittent ☐ Occasionally

Activities

Does your child play a sport? ☐ baseball ☐ basketball ☐Football ☐hockey ☐ soccer ☐ volleyball
Other_____

Check any of the following that are affected:
☐ Sleep ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down ☐School ☐Exercise/Sports ☐ Attention/Focus
☐ Communication ☐Eating ☐ Behavior ☐ Other_____

Has your child received treatment for this condition before? ☐ No ☐ Yes

If yes, please explain_____

What makes the problem better?_____ What makes the problem worse?_____

HEALTH GOALS

What are the top 3 health goals for you child?

1._____

2._____

3._____

What would you like to gain from chiropractic care?

☐ Resolve existing condition ☐ Overall Wellness ☐ Both

PREGNANCY & DELIVERY

Please check any applicable intervention or complications:

☐ Breach ☐ Induction ☐ Pain Meds ☐ Epidural ☐ Episiotomy ☐Vacuum Extraction ☐ Forceps

Any evidence of birth trauma? (Bruises, odd shaped head stuck in the birth canal, fast or excessively long birth, respiratory depression, cord around the neck, other)_____
_____

PREVIOUS TREATMENT

Pediatrician_____ Date of last visit_____/_____/_____

Previous Chiropractic Care: ☐ No ☐ Yes Name:_____ Date of last visit_____/_____/_____

Other Health Care Professional_____

Previous Diagnosis_____

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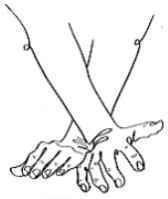

HEALTH HISTORY

Please mark any of the following conditions that your child currently experiences or has ever had

- ☐ Abnormal bleeding
- ☐ Allergies
- ☐ Asthma/Wheezing
- ☐ Bedwetting
- ☐ Cancer
- ☐ Chicken Pox
- ☐ Abdominal pain
- ☐ Colic
- ☐ Congenital heart defect
- ☐ Convulsions/Epilepsy
- ☐ Croup
- ☐ Dental problems
- ☐ Developmental problems
- ☐ Diabetes
- ☐ Diarrhea or Constipation
- ☐ Strabismus (lazy eye)
- ☐ Oral Thrush
- ☐ Pneumonia
- ☐ Blood in urine
- ☐ Body aches / pain
- ☐ Discipline problems
- ☐ Eczema/Skin Problems
- ☐ Emotional problems
- ☐ Ever eating dirt, paint, or plaster
- ☐ Eye problems
- ☐ Frequent colds or sore throats
- ☐ Frequent ear infections
- ☐ Handicaps/Disabilities
- ☐ Hearing problems
- ☐ Heart murmur
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Swollen lymph nodes (adenopathy)
- ☐ Conjunctivitis
- ☐ Nose Bleeds
- ☐ Bronchiolitis
- ☐ Scoliosis
- ☐ HIV/AIDS
- ☐ Irritable/temper problems
- ☐ Kidney/Bladder problems
- ☐ Mouth breather/snoring
- ☐ Mumps, Measles
- ☐ Nightmare/sleep problems
- ☐ Night sweats
- ☐ Pneumonia
- ☐ Reflux
- ☐ Rheumatic Fever
- ☐ Speech problems
- ☐ TB/Lung Disease
- ☐ Thumb sucking
- ☐ Toilet training problems
- ☐ Pigmentation changes
- ☐ Sleep issues
- ☐ Jaundice
- ☐ UTI
- ☐ Change is stool color or form
- ☐ Other _____

Please explain any medical issues that your child has: _____

_____

_____

_____

FAMILY HISTORY (*any parents, siblings, grandparents, aunts & uncles have the following?)*

Mark all that applies

- ☐ Diabetes
- ☐ Breast Cancer
- ☐ Blood Clots
- ☐ Uterine cancer
- ☐ Heart Disease
- ☐ Ovarian Cancer
- ☐ Mental Illness
- ☐ Cancer (other)_____
- ☐ Hight blood pressure
- ☐ Colon Cancer
- ☐ Osteoporosis
- ☐ Stroke
- ☐ High Cholesterol
- ☐ Blood disorders
- ☐ Other_____

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EMOTIONAL STRESS

It is difficult to separate the emotional stress in our life from the physical response that often occurs. Please indicate if your child has ever or is currently experiencing any of the emotional stress below:

☐ academic pressure ☐ loss of a loved one ☐ bullying ☐ relocation ☐ lifestyle change ☐ parent's divorce
☐ loss of a pet ☐ new sibling

Does your child have difficulty interacting with schoolmates or friends? ☐ Yes ☐ No

Have you or anyone else noticed that your child is nervous, twitches, shakes, or exhibits rocking behavior? ☐ Yes ☐ No

Known food sensitivities./allergies: _____
Typical diet: ☐ Mostly whole, organics foods ☐ Pretty average ☐ High amount of processed food

Number of meals each day_____ Number of snacks per day_____

Has your child been vaccinated? ☐ Yes ☐ No If yes, which ones and list of reactions to them if any_____

_____

Has your child ever been on any antibiotics? ☐ No ☐ Yes How many courses_____

List any medication, vitamins, herbs, minerals your child is currently taking?_____

_____

Please list any major illnesses, injuries, falls, auto accidents or surgeries including dates: _____

_____

How often is your child using screen time? (Cell phone, iPad, computer/laptop, television) Hours per day_____

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)

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 or 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)*

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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_____

I have read the previous information regarding the risk 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 explained the treatment, the frequency of care, and alternatives to this care. All my questions have been answered to my satisfaction. I agree to this care plan, 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 understood the Office Policies and Informed Consent:

Print Patient Name _____

Print Parent/Guardian Name _____

Parent/Guardian Signature_____ Date _____/_____/_____