RIVER CITY CHIROPRACTIC
577 Braund Street, Onalaska WI 54650
(608) 406-2488

PEDIATRIC CHIROPRACTIC INTAKE

PATIENT INFORMATION Today's Date _____/_____/_____

Name _____ Date of Birth _____/_____/_____ Age _____

Address _____ Sex: Male _____ Female _____

City/State/Zip _____

Authorized Rep/Parent/Guardian _____ Relationship _____

Cell Phone # _____ Home/Other Phone # _____

Email Address _____

How did you hear about our office? (Please circle all that apply) GOOGLE/INTERNET FACEBOOK HEALTH EVENT DOCTOR/MEDICAL PROVIDER FAMILY MEMBER/FRIEND

OTHER: _____ Please tell us whom we can thank for referring you to us _____

Information about Possible Risk of Chiropractic Treatment

_____ I understand that I have the right, as a patient, to be informed about my condition and the recommended integrative and complementary procedure to be used so that I may make an informed decision whether to undergo the procedure after knowing the risks and hazard involved. Chiropractors, medical doctors, and physical therapists using manual therapy treatment for patients are required to explain that there have been rare cases of injury. Appropriate tests will be performed to help identify if you may be susceptible to injury; you will be notified if that is the case. If you have any questions about this, please do not hesitate to speak to your practitioner. As with any health procedure, complications may arise during treatment. These complications include soreness, muscle or ligament strain, fractures, and disk, cardiovascular, or physiotherapy complications. These are extremely rare occurrences.

Authorization to treat a minor (under the age of 18)

_____ I hereby request and authorize my doctor at this clinic to perform diagnostic tests and render chiropractic adjustments and other treatment to my minor son/daughter. This authorization also extends to all other doctors and interns in this clinic and is intended to include radiographic examination at the doctor's discretion. As of this date, I have legal right to select and authorize health care services for the minor child named below. If my authority to select and authorize this care should be revoked or modified in anyway, I will immediately notify River City Chiropractic.

_____ _____
Print Name of Patient Relationship to Patient

_____ _____
Signature of Patient or Responsible Party Date

PEDIATRIC INTAKE HEALTH QUESTIONNAIRE

Present complaint: _____ When did this begin? _____

Was there an accident or injury involved? Y N Describe: _____

Has your child had any other treatment for this complaint? Y N Describe: _____

Current Medications: _____

GENERAL HEALTH/PRENATAL HISTORY

Any complications during pregnancy? Y N Describe: _____

Medications taken during pregnancy: _____

Tobacco or alcohol during pregnancy? Y N Birth intervention? _____ Forceps _____ Vacuum _____ C-section

Complications during delivery? Y N Describe: _____

How many times has your child been prescribed antibiotics in the past 6 months? _____ Total in lifetime: _____

Has your child received vaccinations? Y N

Number of hours your child sleeps: _____ Hours per night _____ Hours per day/naps

Sleep quality: _____ Good _____ Fair _____ Poor

FEEDING HISTORY

Breast fed? Y N How long? _____ Formula fed? Y N How long? _____

Introduced to: Solids at _____ months Cows milk at _____ months

Food allergies or intolerances? Y N Explain: _____

How would you rate your child's diet? _____ Well balanced _____ Average ____High sugar/processed foods

DEVELOPMENTAL HISTORY

During development, your child's spine is the most vulnerable to stress and should be routinely check by a Doctor of Chiropractic for prevention and early detection of vertebral subluxation (spinal nerve interference). At what age was you child able to:

_____ Respond to sound _____ Sit up alone _____ Stand alone

_____ Hold head up alone _____ Respond to visual stimuli _____ Crawl

_____ Walk alone

Has your child ever been involved in a car accident? Y N Explain: _____

Other trauma not described above? Y N Explain: _____

Prior Surgeries? Y N Explain: _____

Please check if your child has had any of the following:

☐ Acid reflux	☐ Colic	☐ Headaches	☐ Scoliosis
☐ ADD/ADHD	☐ Digestive problems	☐ Hip dysplasia	☐ Seizures
☐ Allergies	☐ Ear infections	☐ Learning difficulties	☐ Sleep problems
☐ Asthma	☐ Frequent fever	☐ PDD/Autism	☐ Tonsillitis
☐ Bedwetting	☐ Growing pains	☐ Postural imbalances	☐ Torticollis

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OFFICE FINANCIAL POLICY

DIRECT PAY: _____ This office accepts all major credit cards, cash, and personal checks.

INSURANCE: MEDICAL _____ AUTO _____ PI _____ W/C _____

It is the patient's responsibility to pay the insurance co-payment on the date of service. Any co-insurance and/or non-covered services are expected to be paid at the time of service, or when the patient/responsible party is billed. The office may make payment plan arrangements on an individual basis. Any such plan or arrangement must be made before the account is past due.

River City Chiropractic accepts assignment as a courtesy to the patient. Should the insurance company not pay any of the anticipated charges for any reason, the patient/responsible party is ultimately responsible for the entire bill. We are not the mediator between you and the insurance company, and we will not enter into any dispute with them, as your contract is between you and your insurance company.

All insurance payments, regardless of which company issues check first, are applied to the patient's account if any balance is due. Refunds are only made after a patient's balance is completely cleared with this office.

If the patient changes contact information or insurance companies, the patient agrees to provide the doctor's office with current information as soon as it is available.

Please read thoroughly, initial at each section and sign at the bottom. Thank you.

Authorization to release information

_____ I have been given access to the Privacy Notice and understand my rights contained in the notice. By way of signature, I authorize this healthcare facility to release all information related to the care I receive for the purposes of treatment, payment, and health care operations as described in the Privacy Notice.

Assignment of Benefits

_____ I assign all benefits payable to me for my care to River City Chiropractic S.C. I understand that this health care facility will be paid directly by the insurance company or other payer. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is considered as valid as the original.

Guarantee of Payment

_____ I guarantee payment of all charges incurred for treatment in accordance with the rates and terms of this healthcare facility.

I have read and understand the Office Financial Policy and agree to abide by these terms.

_____ _____
Print Name of Patient Relationship to Patient

_____ _____
Signature of Patient or Responsible Party Date