



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

## YOUTH 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

# YOUTH 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

Genetic disorders or disabilities: \_\_\_\_\_

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

Has your child received vaccinations? Y N

Has your child been in any high impact or contact sport (soccer, gymnastics, baseball, martial arts, etc.)? Y N

Explain: \_\_\_\_\_

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: \_\_\_\_\_

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

Sleep quality: \_\_\_\_\_ Good \_\_\_\_\_ Fair \_\_\_\_\_ Poor

## NUTRITION

Food allergies or intolerances: Y N List: \_\_\_\_\_

How would you rate your child's diet? \_\_\_\_\_ Well balanced \_\_\_\_\_ Average \_\_\_\_\_ High sugar/processed foods

Does your child consume artificial sweeteners? Y N

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

- |                                      |   |  |   |
|--------------------------------------|---|--|---|
| <input type="checkbox"/> Acid reflux | <input type="checkbox"/> Colic              | <input type="checkbox"/> Headaches             | <input type="checkbox"/> Scoliosis      |
| <input type="checkbox"/> ADD/ADHD    | <input type="checkbox"/> Digestive problems | <input type="checkbox"/> Hip dysplasia         | <input type="checkbox"/> Seizures       |
| <input type="checkbox"/> Allergies   | <input type="checkbox"/> Ear infections     | <input type="checkbox"/> Learning difficulties | <input type="checkbox"/> Sleep problems |
| <input type="checkbox"/> Asthma      | <input type="checkbox"/> Frequent fever     | <input type="checkbox"/> PDD/Autism            | <input type="checkbox"/> Tonsillitis    |
| <input type="checkbox"/> Bedwetting  | <input type="checkbox"/> Growing pains      | <input type="checkbox"/> Postural imbalances   | <input type="checkbox"/> 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