surfside
CHIROPRACTIC
A place for health and healing

CHILDREN'S INTAKE FORM

Patient Name____ M /F Birth Date _____________________ Age ____

Name of Parents / Guardians____

Address ____City ______________________State _____Zip_____________

Home Phone___________________ Cell Phone___________________ Email Address______________________________

SS#____________________________ Height_______ Weight___________ Number of siblings_______

Who referred you to us? ____

HEALTH HISTORY

Name of Pediatrician/ Clinic: ____ Date of last visit ______________

Medications and conditions being treated: ____

Has your child ever taken antibiotics? Y/N Condition treated: ____

Has your child been injured participating in contact sports (Soccer, Football, Martial Arts…) Y/N If yes, describe (Sprain,

Broken Bone, Head Trauma…) ____

Has your child ever been involved in a car accident? Y/N Date & Injuries ____

Has your child ever fallen head first from (Changing Table, Bed, Stairs…) Y/N______________________________________

Other traumas not described above? Y/N Type & Date: ____

Prior surgery: Y/N Type and Date:____ Menarche: Y/N Age:________

Please list any know allergies: ____

Has your child received vaccinations? Y/N Type & Date: ____

Please list any childhood diseases: ____

Other Health Problems: ____

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NAME: ____ **DATE:** ________________________

REASON FOR VISIT: ____

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Have you noticed any changes in your child: ____

Has child seen other doctors for this condition Y/N Who/What specialty: ____________________________________

Symptoms: Please check any current or past problems your child has on the list below:

□Dizziness	□Allergies	□Diarrhea	□Broken bones
□ADHD	□Runny Nose	□Poor Appetite	□Sprains/Strains
□Backaches	□Itchy Eyes	□Behavioral	□Neck Pain
□Heart Condition	□Rashes	□Poor Memory	□Arm/Elbow Pain
□Diabetes	□Unusual Moles	□Insomnia	□Leg/Hip Pain
□Tuberculosis	□Neuritis	□Nightmares	□Knee/Foot Pain
□Fever/Chills	□Digestive	□Bed Wetting	□Growing pains
□Frequent Colds	□Sinus Trouble	□Pain Urinating	□Joint Pain
□Arthritis	□Cough/Wheeze	□Convulsions	□Scoliosis
□Headaches	□Chest Pain	□Paralysis	□Blood disorders
□Asthma	□Constipation	□Muscle Pain	□Hernias
□Chronic ear aches	□Anemia	□Fainting	□Stomach Aches
□Hypertension	□Rheumatic Fever	□Hyperactivity	□Other

Additional information/ comments: ____

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CONSENT TO CHIROPRACTIC CARE

I certify that the information that I have supplied is correct and accurate to the best of my knowledge.
I, ____________________________, being the parent or legal guardian of _________________________ hereby grant permission for my child to receive chiropractic care.

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payer's to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your health information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

Guardian's Name ____ Relationship ________________________

Guardian's Signature Authorizing Care:____ Date:_________________

ACKNOWLEDGMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

______________________________ __________________

Patient Name (please print) Date

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Parent, Guardian or Patient’s legal representative

____

Signature

THIS FORM WILL BE PLACED IN THE PATIENT’S CHART AND MAINTAINED FOR SIX YEARS.

List below the names and relationship of people to whom you authorize Surfside Chiropractic to release PHI.

____________________________ ____________________________

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