

Pediatric Intake Form (Birth to 12 years old)

Date: _____

Patient Information:

Child's Name _____ Date of Birth _____
Last First Middle

Parent / Guardian Name _____ Date of Birth _____
Last First Middle

(Complete Mailing)

Address _____
Street Apt# City State Zip

Home Phone # _____ ** Work Phone # _____ **

Cell Phone # _____ ** Email address _____

If you would like to opt-out of receiving email notifications from our office, please initial here _____ **

How did you hear about us? Referral | Mail | Website | Phonebook | Internet search | Insurance
Who may we thank for referring you to our office? _____

Is this visit routine/accident/illness/other: _____ If Accident (date) _____

Insurance and Payment Information

Do you intend to use health insurance? Yes No
Are you covered by Medicare? Yes No
Are you covered by Medicaid? Yes No

Insurance Information: Ins. Company _____
Policy holder name/Date of Birth/Relation (if different than above) _____
Insurance ID# _____ Group ID# _____ Copay? _____

Please notify our staff if there is an alternate address / phone number or form of communication that you wish us to contact you by other than your listed information above. Your information will never be sold, shared or distributed.

Other Pediatric Provider Name/Phone #: _____

Has your child seen a chiropractor before? Yes No
Previous Chiropractor Name / Phone #: _____

ACKNOWLEDGEMENT AND UNDERSTANDING

Please initial each item below.

1. _____ I hereby authorize City Fit Family Chiropractic Center LLC and the doctors on staff to provide Chiropractic and other necessary health care services for my child as they deem appropriate.
2. _____ I understand and agree that all services rendered to my child at this office are my responsibility, regardless of insurance coverage. I have read and signed the clinic financial policy and understand that even if submitted to insurance, I am ultimately personally responsible for payment.
3. _____ If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and cost of collections.
4. _____ I hereby assign all chiropractic benefits, including major medical benefits to which my child is entitled, Medicare, private insurance and all other health plans, to Andrea L Herrst, DC and City Fit Family Chiropractic Center LLC, 319 SW Washington St, Suite 1001, Portland OR 97204, pursuant to the clinic financial policy I have signed.
5. _____ I authorize release of patient records to third parties requiring these records for determination of financial liability
6. _____ I authorize release of my child's personal health records (including chart notes, x-rays, examination forms, et al) to Andrea L Herrst, DC and City Fit Family Chiropractic Center LLC, and to requesting third parties with proper authorization, for purposes of coordinating and informing my treatment while under care in this office. I can revoke this authorization by submitting a written notice to Andrea L Herrst, DC, c/o City Fit Family Chiropractic Center LLC, 319 SW Washington St, Suite 1001, Portland OR 97204.
7. _____ Email: Email is not to be used for appointment scheduling, sensitive and/or urgent matters. Reply times will depend on when email is accessed and can range from one to several days. Please be aware that Dr. Herrst may not access email while on vacation. Email may entail some privacy risks and is not HIPAA compliant. If you choose to communicate by email, you accept this risk. Please be concise; if Dr. Herrst cannot answer you very briefly, the matter is probably more complicated and should be addressed at the next office visit. If you choose to communicate by email, Dr. Herrst reserves the right to charge a consultation fee for these services if necessary.

By signing this application I affirm that I have given true and complete information.

Dated this _____ day of _____ 20_____.

Guarantor Signature

Relationship to Patient

AUTHORIZATION TO TREAT A MINOR

As a parent or legal guardian having legal custody or guardianship of the below named minor child, authorize, request and direct Dr. Andrea L Herrst, DC and whomever she may designate as assistant to perform in judgment any examination, diagnosis and chiropractic or other appropriate treatment deemed advisable and as explained in the informed consent I have read and signed.

Patient's full name _____ Date of Birth _____
Signature _____ Date _____ Witnessed by _____
(Parent or Guardian)

Childs' Name: _____ **Date of Birth:** _____ **M / F** _____ **Date:** _____

Prenatal History

Is your child adopted? Yes No

Did you have any pregnancy-related complications? Yes No

If yes, please describe _____

Place of birth: Home Birthing Center Hosptial

Provider: Midwife OB-GYN Other: _____

Type of Birth: Vaginal C-section

Were pain medications used? Yes No

Was labor induced? Yes No

If yes, please describe _____

What position did you deliver in? Squatting On Back Water birth Other: _____

Was labor assisted by: Doctor pulling Vacuum Forceps None

Did your child have a misshapen skull or head? Yes No

Were there purple markings on their face? Yes No

Medical History

Did you breast feed your child? Yes No

Does your child prefer one breast over the other? Yes No

If yes, which side? Right Left

Has your child been immunized? Yes No

Reason for immunization: Informed decision Recommended Didn't know I had a choice

Did your child have any negative reaction to the vaccinations? Yes No

If yes, were they reported? Yes No

Has your child had any surgeries? Yes No

If yes, please describe _____

Is your child currently taking any medications? vitamins? Yes No

If yes, please describe _____

Baby / Toddler (age 0-4)

Have any of the following occurred? (please circle)

Fall from changing table	Frequent crying spells	Tumble down stairs	Car accident
Fall out of crib	Fall on playground	Frequent ear infections	Tonsillitis
Frequent fevers	Frequent diarrhea	Constipation	Colic
Sleeping problems	Frequent colds	Weight gain / loss	Other

Child (age 5-12)

Have any of the following occurred? (please circle)

Fall from a tree	Fall off a bicycle	Sports accident	Car accident
Stomach pains	Scoliosis	Bed wetting	Fall on playground
Hyperactivity	Autism	Asthma	Allergies
Leg / knee pains	Growing pains	Other	

Daily Habits and Activities

Does your child participate in any of the following (please circle)

Soccer	Football	Gymnastics	Karate	Hockey	Lacrosse	Basketball
Wrestling	Baseball	Softball	Volleyball	Tennis	Dance	Swimming

Other Sport: _____

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

Does your child consume artificial sweeteners? Yes No

Does your child drink water? Yes No

Number of hours your child sleeps? _____ Hours per day Sleep quality? Good Fair Poor

Child's Name: _____

Date of Birth: _____

M / F

Date: _____

Please tell us about your child's health. Please place an **X** in the box if the the sentence applies to your child. This will help your doctor plan your child's physical exam.

Growth

I am concerned about my child's growth.

Appetite

I am concerned about my child's eating / feeding habits or appetite.

Rest

I am concerned about the amount of sleep my child needs or is not getting.

Illness/Surgery/Injury

My child had a serious illness, injury or surgery. *Please describe* _____

Physical Activity

My child must restrict physical activity. *Please describe* _____

Development and Learning

I am concerned about my child's behavior, development or learning. *Please describe* _____

Allergies

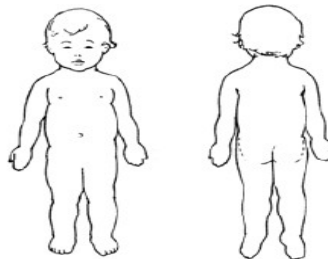
My child has allergies (medicine, food, dust, mold, pollen, insects, animals, etc) *Please describe* _____

Body Health

My child has problems with

Skin, birthmarks, Mongolian spots, hair, fingernails, toenails.

Please map and describe color/shape of skin markings, birthmarks, scars, moles, etc, on the figure below.



- Eyes / vision, glasses
- Ears / hearing, hearing aides or device, earaches, tubes in ears
- Nose problems, nosebleeds, runny nose
- Mouth, teething, gums, tongue, sores in mouth or on lips, mouth-breathing, snoring
- Frequent sore throats or tonsillitis
- Breathing problems, asthma, cough, croup
- Heart, heart murmur
- Stomach aches, upset stomach, colic, spitting up, vomiting
- Using toilet, toilet training, urinating, bed wetting
- Bones, muscles, movement, pain with movement, problems with moving to one side
- Nervous system, headaches, seizures, nervous habits (like twitches)
- Needs special equipment. *Please describe* _____
- Sleep, sleep walking, head rolling

Parent Questions or Comments for Doctor:

Parent or Guardian Signature

Date

 Clinician Signature / Date