

PEDIATRIC INTAKE FORM

Date: _____

PERSONAL INFORMATION

Child's First Name: _____ M.I.: _____ Last Name: _____

Preferred Name: _____ Social Security Number: _____

Address: _____

City / State / Zip: _____

Birth Date: _____ Age: _____ Sex: M F

of Siblings: _____

Sibling(s) Names & Ages: _____

Parents' Names: _____

Best Contact Phone: () _____

Alternate Phone: () _____

Email: _____

Who can we thank for referring you or how did you hear about Basler Family Chiropractic?

REASON FOR SEEKING CARE

What is your reason for seeking care at Basler Family Chiropractic? _____

When did this begin? (If applicable) _____

Are there any major injuries and/or surgeries we should know about? _____

What is this affecting that is MOST important in your child's life? (List all that apply)

Has your child seen any other providers for this condition? (List all that apply)

Has your child seen a chiropractor before? Yes No

How long ago? _____ Clinic/Doctor Name: _____

What is your reason for the change? (If applicable) _____

What is your level of commitment to your child's health? 1 2 3 4 5 6 7 8 9 10

Explain: _____

What health goal, if your child were to complete or accomplish it, would have the greatest impact on his/her life? _____

HEALTH CONCERNS

- | | |
|--|--|
| <input type="checkbox"/> Anxiety/Depression | <input type="checkbox"/> Fatigue/Sleep Issues |
| <input type="checkbox"/> Constipation/Diarrhea | <input type="checkbox"/> Asthma/Chronic Bronchitis |
| <input type="checkbox"/> Nausea/Vomiting | <input type="checkbox"/> Colic/Acid Reflux |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Back/Neck Pain/Stiffness |
| <input type="checkbox"/> Bed Wetting | <input type="checkbox"/> Difficulty Gaining Weight |
| <input type="checkbox"/> Overweight | <input type="checkbox"/> Ear or Other Infections |
| <input type="checkbox"/> Frequent Sickness | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Learning Disorders |
| <input type="checkbox"/> Detachment/Distant | <input type="checkbox"/> Sinus Troubles/Allergies |
| <input type="checkbox"/> Irritability/Nervous | <input type="checkbox"/> Autism/Asperger's |
| <input type="checkbox"/> Other _____ | |
| <input type="checkbox"/> Other _____ | |
| <input type="checkbox"/> Other _____ | |

Explain any boxes checked above:

Is there anything else regarding your child's current condition you feel the doctor should know? _____

MEDICATIONS

- | | |
|---|--|
| <input type="checkbox"/> Anxiety/Depression | <input type="checkbox"/> Migraine/Headache |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Acid Reflux |
| <input type="checkbox"/> Pain Narcotics | <input type="checkbox"/> ADD/ADHD |
| <input type="checkbox"/> Antibiotics | <input type="checkbox"/> Digestive |
| <input type="checkbox"/> Other _____ | |
| <input type="checkbox"/> Other _____ | |
| <input type="checkbox"/> Other _____ | |

Explain any boxes checked above: _____

Did You Know...

Each health concern relates to a specific area of the spine and nervous system? Please circle below or enter the information to the left.

Sore Throat
Stiff Neck
Radiating Arm Pain
Hand/Finger Numbness
Asthma
Allergies
High Blood Pressure
Heart Conditions

Headaches
Migraines
Dizziness
Sinus Problems
Allergies
Fatigue / Sleep Problems
Head Colds
Vision Problems
Difficulty Concentrating
Hearing Problems

Middle Back Pain
Congestion
Difficulty Breathing
Bronchitis
Pneumonia
Gallbladder Conditions
Stomach Problems
Ulcers
Gastritis
Kidney Problems
Indigestion

Constipation
Colitis
Diarrhea
Gas Pain
Irritable Bowel
Bladder Problems
Menstrual Problems
Low Back Pain
Pain or Numbness in Legs
Reproductive Problems

VITAMINS / SUPPLEMENTS

- | | |
|--|---|
| <input type="checkbox"/> Multi-Vitamin | <input type="checkbox"/> Fish Oil/Omega-3 |
| <input type="checkbox"/> Vitamin D3 | <input type="checkbox"/> Probiotics |
| <input type="checkbox"/> Other _____ | |
| <input type="checkbox"/> Other _____ | |
| <input type="checkbox"/> Other _____ | |

Explain any boxes checked above:

PRENATAL HISTORY

Location of birth: Home Birthing Center Hospital Other: _____

Did any of the following happen during delivery:

C-section delivery Doctor pulled or twisted baby Anesthesia Labor was induced
Forceps/vacuum extraction Premature delivery Special medical procedures/tests

Describe any of the above plus any additional complications experienced during delivery:

During pregnancy, did you use any drugs, tobacco, alcohol, and/or medications? If yes, please list:

Did you experience any illness while pregnant? Yes No If yes, explain: _____

Do you have any physical disabilities? Yes No If yes, explain: _____

Birth weight: _____ Birth length: _____ APGAR scores (if remembered): _____

Ultrasound used during pregnancy? Yes No Number of times: _____

Did you breastfeed the baby? Yes No If yes, how long: _____

Did you formula-feed the baby? Yes No If yes, how long: _____

At what age did you introduce: Solids: _____ Cow's milk: _____

LIFESTYLE HABITS

Does your child exercise daily? Yes No How much? _____

Does your child drink soda? Yes No How much/often? _____

Does your child have a positive self-esteem or self-image? Yes No

Does your child watch more than an hour of TV per day? Yes No How much? _____

Does your child eat balanced meals? Yes No

Does your child experience prolonged sadness? Yes No Explain: _____

Does your child have difficulty sleeping? Yes No Explain: _____

Does your child play video games? Yes No How much? _____

CURRENT HEALTH STATUS

The National Safety Council reports approximately 50% of children fall head first from a high place during their first year of life (bed, changing table, stairs, etc.). Was this the case for your child? Yes No Explain: _____

Has your child ever been hospitalized or had surgery? Yes No Explain: _____

Does your child have difficulty interacting with others? Yes No Explain: _____

Have you noticed that your child is nervous, twitches, shakes, or exhibits rocking behavior? Yes No Explain: _____

Has your child been involved in any high impact/contact sports (soccer, football, martial arts, cheerleading, etc.)? Yes No
Please list: _____

Are you aware of any food allergies or intolerance? Yes No Explain: _____

Has your child received all recommended vaccinations? Yes No Explain: _____

Please rate stress levels on a scale of 1-10 (10 being highest)

School: 1 2 3 4 5 6 7 8 9 10 Personal: 1 2 3 4 5 6 7 8 9 10

PERMISSION TO TREAT A MINOR

I, (Parent/Guardian) _____, give Basler Family Chiropractic permission to examine, x-ray (if necessary), and treat _____.

Minor date of birth: _____

Parent/Guardian Signature: _____ Date: _____

Witness Signature: _____

INFORMED CONSENT

I hereby authorize doctors and staff at Basler Family Chiropractic to treat my child's condition as deemed appropriate. At Basler Family Chiropractic, we do not diagnose or treat any disease or condition other than vertebral subluxation and the doctor/clinic will not be held responsible for any pre-existing medical conditions. I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any staff member of Basler Family Chiropractic responsible for any errors or omissions that I may have made in the completion of this form. Chiropractic, as well as all other types of health care, is associated with potential risks in the delivery of treatment. While chiropractic treatment is remarkably safe, you need to be informed about the potential risks related to your care to allow you to be fully informed before consenting to treatment. I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risks are most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rate between one instance per million to one per two million, have been associated with chiropractic adjustments. Please inquire if you have further questions. Chiropractic is a system of health care delivery and therefore, as with any health care delivery system, we cannot promise a cure for any symptom, condition, or disease as a result of treatment in this office. An attempt to provide you with the very best care is our goal, and if the results are not acceptable, we will refer you to another provider who we feel can further assist you.

Treatment objectives as well as the risks associated with chiropractic adjustments and, all other procedures provided at Basler Family Chiropractic have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

Also, it is the desire of this office to provide chiropractic care in an "open-door" adjusting environment. An "open-door" approach involves the doctor moving from patient care area to patient care area and leaving the doors between patient care areas open. As a result patients are occasionally within sight of one another and some ongoing routine details of care are discussed within earshot of other patients and staff. This environment is used for ongoing care and is NOT the environment used for taking patient histories, performing examinations or presenting reports of findings. These procedures are completed in a private confidential setting.

I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of my care in this office. _____ Initials

Date: _____ Parent/Guardian Signature : _____

FINANCIAL POLICY

Our goal is to provide the highest quality of healthcare possible of our patients. In order to achieve this goal, we need your commitment as well.

- We urge our patients to follow the doctor's recommendations for care. Please keep your appointments as scheduled or call our office within 24 hours to make any changes. In order to attain the level of achievement we both desire, care must be followed.
- I authorize Basler Family Chiropractic to release any information deemed appropriate concerning my physical condition to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred by me.
- I authorize the direct payment to Basler Family Chiropractic of any sum I now or hereafter owe by my attorney out of settlement of my case, and by and insurance company obligated to make payment to me or Basler Family Chiropractic based in whole or in part upon the charges made for services received.
- I hereby appoint Basler Family Chiropractic authority to endorse and cash checks, drafts, or money orders made payable to the undersigned or as co-payee with this clinic for payments due for services rendered on behalf of the undersigned by Basler Family Chiropractic.
- In order to file your claims in a timely manner, we need current, accurate insurance information for you and your dependents. We will do our best to confirm your eligibility and level of insurance coverage for care; however, it is ultimately your responsibility to know your own insurance benefits in relation to what your insurance covers and what it doesn't. Should your insurance carrier determine that any or all of our services are ineligible for payment, you will be billed directly for those services.
- Late payment of non-coverage, deductible, and co-payment may be subject to an 18% annual finance charge, which will be added monthly to that account.
- If you have any questions about our financial policies, please ask to speak to our financial officer. If you need to make special arrangements, please ask. We will never deny care to anyone based solely on ability to pay.
- I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. This chiropractic office will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to this chiropractic office will be credited to my account upon receipt. However, I clearly understand and agree that all service rendered to me are charged directly to me and that I am personally responsible for payment.

Date: _____ Parent/Guardian Signature : _____

Basler Family Chiropractic NOTICE OF PRIVACY PRACTICE

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your **Personal Health Information**. In addition we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or as **dictated by our office policy**, we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. In addition, you will find we have placed several copies in report folders labeled **'HIPAA'** on tables in the reception. Once you have read this notice, please sign the last page, and return only the signature page (page 2) to our front desk receptionist. Keep this page for your records.

PERMITTED DISCLOSURES:

1. Treatment purposes - discussion with other health care providers involved in your care.
2. Inadvertent disclosures - open treating area mean open discussion. If you need to speak privately to the doctor, please let our staff know so we can place you in a private consultation room.
3. For payment purposes - to obtain payment from your insurance company or any other collateral source.
4. For workers compensation purposes - to process a claim or aid in investigation.
5. Emergency - in the event of a medical emergency we may notify a family member.
6. For Public health and safety - in order to prevent or lessen a serious or eminent threat to the health or safety of a person or general public.
7. To Government agencies or Law enforcement - to identify or locate a suspect, fugitive, material witness or missing person.
8. For military, national security, prisoner and government benefits purposes.
9. Deceased persons - discussion with coroners and medical examiners in the event of a patient's death.
10. Telephone calls or emails and appointment reminders - **we may call your home and leave messages** regarding a missed appointment or apprise you of changes in practice hours or upcoming events.
11. Change of ownership- in the event this practice is sold, the new owners would have access to your PHI.

YOUR RIGHTS:

1. To receive an accounting of disclosures.
2. To receive a paper copy of the comprehensive "Detail" Privacy Notice.
3. To request mailings to an address different than residence.
4. To request Restrictions on certain uses and disclosures and with whom we release information to, although we are not required to comply. If, however, we agree, the restriction will be in place until written notice of your intent to remove the restriction.
5. To inspect your records and receive one copy of your records at no charge, with notice in advance.
6. To request amendments to information. However, like restrictions, we are not required to agree to them.
7. To obtain **one copy** of your records at no charge, when timely notice is provided (72 hours). **X-rays** are original records and you are therefore not entitled to them. If you would like us to outsource them to an imaging center, to have copies made, we will be happy to accommodate you. However, you will be responsible for this cost.

COMPLAINTS:

If you wish to make a formal complaint about how we handle your health information, please call Alisha at 406-257-3004. If she is unavailable, you may make an appointment with our receptionist to see her within 72 hours or 3 working days. If you are still not satisfied with the manner in which this office handles your complaint, you can submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Ave. SW
Room 509F HHH Building
Washington DC 20201

Patient initials: _____-retaining page 1 of 2

Basler Family Chiropractic NOTICE REGARDING YOUR RIGHT TO PRIVACY continued...

I have received a copy of Basler Family Chiropractic Patient Privacy Notice. I understand my rights as well as the practice's duty to protect my health information, and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this "Notice of Privacy Practice" at a time in the future and will make the new provisions effective for all information that it maintains past and present.

I am aware that a more comprehensive version of this "Notice" is available to me and several copies kept in the reception area. At this time, I do not have any questions regarding my rights or any of the information I have received.

Patient's Name

DOB

Patient's Signature

Date

Witness

Date