BASLER
— FAMILY CHIROPRACTIC —

PEDIATRIC INTAKE FORM

DATE

PERSONAL INFORMATION

CHILD'S NAME (FIRST, MIDDLE INITIAL, LAST)

PREFERRED NAME

ADDRESS

BIRTH DATE AGE

CITY STATE ZIP CODE

SIBLING(S) NAMES & AGES (ACCOUNTS TO BE LINKED)

SEX: ☐ MALE ☐ FEMALE NUMBER OF SIBLINGS: _____

PARENTS' INFORMATION

PARENTS' NAME

BEST CONTACT PHONE

EMAIL

ALTERNATE PHONE

WOULD YOU LIKE YOUR STATEMENT EMAILED? ☐ YES ☐ NO

Who may we thank for referring you?

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?

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 & HISTORY

BASLER
FAMILY CHIROPRACTIC

HEALTH CONCERNS

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

Explain any boxes checked above:

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

MEDICATIONS

☐ Anxiety/Depression ☐ Migraine/Headache
☐ Asthma ☐ Acid Reflux
☐ Pain Narcotics ☐ ADD/ADHD
☐ Antibiotics ☐ Digestive
☐ Other _____
☐ Other _____
☐ Other _____

Explain any boxes checked above:

VITAMINS | SUPPLEMENTS

☐ Multi-Vitamin ☐ Fish Oil/Omega-3
☐ Vitamin D3 ☐ Probiotics
☐ Other _____
☐ Other _____
☐ 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? ☐ No
☐ Yes, _____

Do you have any physical disabilities? ☐ No
☐ Yes, _____

Birth Weight _____ Birth Length _____
APGAR scores (if remembered): _____

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

Did you breastfeed the baby? ☐ Yes ☐ No
How long? _____

Did you formula-feed the baby? ☐ Yes ☐ No
How long? _____

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

HEALTH HABITS

DOES YOUR CHILD:
Exercise ☐ Daily ☐ Weekly How much? _____
Soda ☐ Daily ☐ Weekly How much? _____
Television ☐ Daily ☐ Weekly How much? _____
Video Games ☐ Daily ☐ Weekly How much? _____
Have a positive self-image? ☐ Yes ☐ No
Eat balanced meals? ☐ Yes ☐ No
Difficulty sleeping? ☐ No
☐ Yes, _____
Experience prolonged sadness? ☐ No
☐ Yes, _____

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

CURRENT HEALTH

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? ☐ No ☐ Yes, _____

Has your child ever been hospitalized or had surgery?
☐ No ☐ Yes, _____

Does your child have difficulty interacting with others?
☐ No ☐ Yes, _____

Nervous, twitches, shakes, or exhibits rocking behavior?
☐ No ☐ Yes, _____

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

Are you aware of any food allergies or intolerance?
☐ No ☐ Yes, _____

Has your child received all recommended vaccinations?
☐ No ☐ Yes, _____

INFORMED CONSENT

BASLER
FAMILY CHIROPRACTIC

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 child's care in this office. Initial here _____

Whom may we discuss your child's care with? _____

Date: _____ Parent/Guardian Signature : _____

FINANCIAL POLICY

BASLER
FAMILY CHIROPRACTIC

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 : _____

NOTICE OF PRIVACY PRACTICE

BASLER
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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.

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 apprize 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 request amendments to information. However, like restrictions, we are not required to agree to them.
6. To obtain one copy of your records at no charge, when timely notice is provided (72 hours). X-rays are original records and therefore you are 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 Dr. Basler at 406-257-3004. If he is unavailable, you may make an appointment with our receptionist to see him 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

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.

Date:_____ Parent/Guardian Signature : _____