Live Empowered Chiropractic LLC

Pediatric Intake Form

Name _____
Date _____
Address _____
City _____ State ____ Zip _____
Date of Birth _____ (Age _____)

Parent A's Name_____
Parent B's Name_____
Phone: _____
E-mail _____

Whom may we thank for referring you to our office? _____
Our goal is to bring better health to our community. The best way for us to reach others is through word of mouth & satisfied patient referrals. The greatest compliment a patient can give us is a referral of friends and family.

Please tell us your top 3 health goals:
1. _____
2. _____
3. _____

Current Health Condition

What concerns/conditions do you feel we can address for you?

_____
Pain or Problem started on_____

Pains are: ❒ Sharp ❒ Dull ❒ Constant ❒ Intermittent

What activities aggravate your condition/pain? _____
What activities lessen your condition/pain? _____
Is condition worse during certain times of the day? _____
Is this condition interfering with work? _____ Sleep? _____ Routine? _____ Other? _____
Has this condition STAYED THE SAME GETTING BETTER GETTING WORSE
Other Doctors seen for this condition _____
Any home remedies? _____

Check any of the following conditions your child has experienced from during the past six months:

❒ Sleeping Problems	❒ Irritability	❒ Asthma
❒ Light Sensitivity	❒ Scoliosis	❒ Poor Coordination
❒ Ear Infection	❒ Colic	❒ ADHD
❒ Temper Tantrums	❒ Vision Changes	❒ Recurring Fevers
❒ Growing Pains	❒ Loss of Balance	❒ Allergies
❒ Reoccurring Colds	❒ Digestive Problems	❒ Bed Wetting
❒ Fainting	❒ Seizures	❒ Nursing Problems
❒ Dental problems		❒ Constipation

Other_____

Medical History

Approximately 50% of children fall head first from a high place during their first year of life (i.e. bed, changing table, down stairs, etc.). Was this the case for your child? ❒ Yes ❒No
Has your child ever been involved in a car accident? ❒ Yes ❒No If yes, please explain:

_____
_____

Please list any major injuries, accidents, falls and/or fractures your child has had in his/her lifetime.

_____
_____

Please list below all surgeries and hospitalizations.

Have you chosen to vaccinate your child? ❒Yes ❒ No
Please describe any and all reactions to vaccine(s)

Please check all that apply to your child and give any necessary details:
❒ Uncoordinated/Accident prone _____
❒ Has/had a chronic illness _____
❒ Has taken antibiotics _____
❒ Currently taking supplements/vitamins/herbs/homeopathics

❒ Currently taking medication _____
Has your child ever received Chiropractic care? Y N
Name of D.C._____
How long under care? _____

Family History:

	Heart Disease	Arthritis	Cancer	Diabetes	Other _____
Father's Side	❒	❒	❒	❒	❒
Mother's Side	❒	❒	❒	❒	❒

Your oldest grandparent on record lived to the age of _____.
❒ Still living ❒ Deceased

Pregnancy & Birth

Our ❒ Obstetrician ❒ Midwife ❒Family Physician ...was _____
During pregnancy, did you/the mother:
Experience any significant illnesses, difficulties, or trauma? ❒Yes ❒ No If yes, please explain

Take any drugs/medications/supplements? ❒ Yes ❒ No If yes, please explain

Smoke or consume alcohol? ❒ Yes ❒No
Any exposure to ultrasound? ❒ Yes ❒ No If so, how many? _____
Was the delivery premature? ❒ Yes ❒ No Weeks _____Weight _____
Approximately how long did labor last? _____ hours
Was labor artificially induced? ❒ Yes ❒ No If yes, please explain

Was your child in a breech position or otherwise malpositioned? ❒Yes ❒ No
If yes, please explain

Please check where/how your baby was born and if any of the following were administered during labor and birth.
❒ Hospital birth ❒ Birthing Center ❒ Home birth
❒ Vaginal ❒ Scheduled Caesarean ❒ Emergency Caesarean
❒ Vacuum ❒ Water birth ❒Cord around neck
❒ Forceps ❒ Episiotomy ❒ Epidural ❒ Manual traction of the neck
❒ Medications If yes, please explain _____
❒ Other_____
APGAR Score _____/_____
Please check all that apply to your baby's status immediately after birth:
❒Jaundice ❒ Respiratory problems ❒Feeding problem ❒Displaced joints ❒Odd shaped head ❒Broken bones
❒Other conditions_____
Following delivery, was your baby breastfed? ❒ Yes ❒ No If so, for how long?_____

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Birth weight _____ Birth length _____ Current weight _____ Current height _____

Growth & Development

Was your child alert and responsive within 12 hours of delivery? ❒ Yes ❒ No If no, please explain

_____

Does your child have any genetic disorder or disabilities? ❒ Yes ❒ No If yes, please explain

_____

At what age did your child:
Respond to sound _____ Follow an object _____ Hold head up _____ Vocalize _____ Sit alone _____ Teethe _____ Cross crawl _____ Stand alone _____ Walk _____
Is/was your child breastfed? ❒ Yes ❒ No If yes, how long?_____
Formula introduced at age _____ What type?_____
Introduction of cow's milk at age _____
Began solids at age_____
Please list any foods/juice intolerance_____
If breastfed, any difficulty with breastfeeding? ❒Yes ❒No ❒ N/A If yes, please explain

_____

Any difficulty with bonding? ❒Yes ❒ No If yes, please explain

_____

Any behavioral problems? ❒ Yes ❒ No If yes, please explain

_____

Any night terrors, sleep walking or difficulty sleeping? ❒ Yes ❒ No If yes, please explain

_____

Has your child been involved in any high impact or contact-type sports (i.e. soccer, football, gymnastics, baseball, cheerleading, martial arts, etc.)? ❒ Yes ❒ No If yes, please explain

_____

Describe your child's diet? ❒ Mostly whole, organic foods ❒ High amounts of processed foods ❒ Somewhere in between the previous two options
Does your child have regular bowel/bladder movements? ❒Yes ❒ No How often do they go?_____
Does your child have difficulty interacting with schoolmates or friends? ❒ Yes ❒ No
Age of your child when she/he began daycare? _____ ❒ N/A
Average number of hours of TV/computer/iPad/technology per week? _____
Do you feel that your child's social and emotional development is normal for their age? ❒ Yes ❒ No
If no, please explain

_____

Are there any other health concerns or anything else you'd like us to know about your child?

_____

_____

Your child deserves to be healthy. When they were conceived, they were given the blue-prints, intelligence, and systems to live an active, healthy, long life. Unfortunately, the natural expression of health can be interfered with. Through the examination and through your child's involvement in chiropractic care, we will work to remove these interferences and keep them out of their life, so that they can heal quickly and live the quality lifestyle they deserve. The information I have provided on this form is true and accurate to the best of my knowledge. I give Plasker Chiropractic & Functional Neurology permission to consult, program, and advise according to their expertise and experience.

Signature of Parent/Guardian:_____ Date:_____

Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an "arterial dissection" that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately a percentage of these patients will experience a stroke.

The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events/ per one million persons/year and risk of death has been estimated as 104 per one million users.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name: _____ Signature: _____ Date:

Parent or Guardian: _____ Signature: _____ Date:

Witness Name: _____ Signature: _____ Date:

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TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be able to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal evaluation, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. Our only practice objective is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, _____ have read and fully understand the above statements.
(print name)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

_____ _____
(signature) (date

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Office Fee Schedule and Financial Policy

Service	Fees
Consultation	$0
Initial Chiropractic Exam	$195
Re-examination	$35
Adjustment	$55

Financial Policy and Active Life Plans

We are committed to providing you with the best chiropractic care possible in a caring environment and have established our financial policies to achieve that goal. You will be expected to pay for your chiropractic care at the time the service is rendered unless you arrange an Active Life Plan in advance. These plans are designed to be the most cost-effective way to keep you and your family as healthy as possible. They include your Crisis Care, Critical Transition and Lifestyle Care Options. Details of these plans will be discussed with you during your Chiropractic Report. Please choose one of the following documentation options:

- ❑ **Insurance:** If you have insurance that covers chiropractic, we will give you all of the information you need to get reimbursed quickly. This includes your diagnosis, prognosis and copies of your records or reports. We have found it is easier for your record keeping, and ours, if we give you receipts at the end of your first visit and then once a month after that. Just send your receipts with a copy of your claim form to your insurance company, and they will communicate with you about your reimbursement. Remember your agreement with your insurance company is between you and them. Please note that many insurance policies may not reimburse for Critical Transition or Lifestyle Care.

- ❑ **No Insurance:** If you do not have health insurance, choose not to use your health insurance or are participating in Lifestyle Care, you may request a receipt for tax purposes or a Health Savings Account (HSA) indicating the total amount you have paid for chiropractic care during the year. There is no insurance documentation given with these receipts.

  If a special situation arises, such as an auto accident or a worker's compensation injury, a new examination will need to be performed and you will be charged our regular fees until the claim is settled. We will help you get reimbursed as quickly as possible on these claims.

I, (name) _____ have read and I understand the above policies. I have initialed the option that applies to me.

_____ _____

Patient signature Date

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Cancellation Policy & Procedure

At Live Empowered Chiropractic, our goal is to provide you with quality care in a timely manner. We have implemented a no show and cancellation policy which enables us to better utilize available appointments for our patients in need of chiropractic and functional neurology care.

Please be courteous and notify us promptly if you are unable to attend an appointment. This time will be reallocated to someone who is in urgent need of care. Available appointments are in high demand and your early cancellation will give another person the possibility to have access to timely care.

- Patients who fail to show for their scheduled appointment or did not notify the office within 24 hours of their scheduled appointment time, will be subject to a Cancellation fee of the full cost of the appointment. In the event of an actual emergency when prior notice cannot be given, consideration will be held, and a one-time exception may be granted.

- These fees are not covered by insurance and is therefore the sole responsibility of the patient.

To cancel or reschedule appointments call our office at (458) 206-3461. If we are unable to answer the phone, you can leave a message with your name, appointment date and cancellation reason or request for rescheduling.

Patient Signature _____ Date _____

HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been *our* practice for years. This form is a "friendly" version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff . You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.
2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.
3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.
4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.
5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manger or the doctor.
6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.
7. We agree to provide patients with access to their records in accordance with state and federal laws.
8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.
9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I, _____date_____do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

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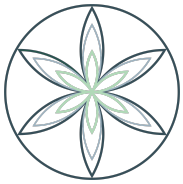

Live Empowered Chiropractic LLC

Patient Name:_____ Date of Birth:_____

I acknowledge that I received and/or reviewed a copy of Live Empowered Chiropractic's's Notice of Privacy Practices.

I give permission to communicate messages in the following manner:

_____ You may leave a message on my answering machine located at this number _____

_____ You may leave a message on my cell phone_____
_____ You may leave a message with my spouse, _____at this number _____

_____ You may leave a message with another person, _____ at this number _____

_____ You may email me regarding my health care at _____

I give permission to communicate messages about the following via phone or email:

_____X-rays, and other test results
_____ Billing or insurance matters

_____ _____

Patient Signature Date