Active Life Chiropractic
Child Intake Form

REMEMBER: Injury to the spine during the birth process, as well as the numerous falls and accidents during childhood could be the unsuspected cause of many health problems in children.

Name of your child _____Parents Name_____

Address _____

City/State/Zip _____ Sex M F Birth date _____

Phone # Home _____ # Work _____ Hours (_ to_)

Who is responsible for your child's bill? □ You □ Spouse □ Auto Insurance

Grade Level _____ Age _____ □ Personal Health Insurance _____

Emergency Contact Name _____Relationship:_____

Address _____

Phone # _____

During pregnancy, was the mother on medication? Did the mother smoke or consume any alcoholic beverages? _____

Was there back pain? _____

Approximately how long was the labor? _____

Was the mother physically ill? (Colds, flu, allergies, German measles, anything like that)

If yes, explain? _____

REGARDING LABOR

Was labor chemically induced?	□ Yes □ No
Doctor assisted? (used hands to pull the baby out)	□ Yes □ No
Was C-section performed?	□ Yes □ No
Were forceps used?	□ Yes □ No
Was a suction cap used?	□ Yes □ No
Was the delivery lying down?	□ Yes □ No
Was a family member present?	□ Yes □ No
If yes, who?	_____
Was the baby premature?	□ Yes □ No
APGAR Scores	_____

Has your child suffered from any health problems, such as :

Headaches	□ Yes □ No	Meningitis	□ Yes □ No
Allergies	□ Yes □ No	Diarrhea	□ Yes □ No
Ear Problems	□ Yes □ No	Constipation	□ Yes □ No
Sleeping Disorders	□ Yes □ No	Colic	□ Yes □ No
Breathing Problems	□ Yes □ No	Rashes	□ Yes □ No
Fatigue	□ Yes □ No	Milk or Lactose Intolerance	□ Yes □ No
Irritability	□ Yes □ No	Bed Wetting	□ Yes □ No
Hyperactivity	□ Yes □ No	Digestive problems	□ Yes □ No
Frequent Colds	□ Yes □ No	Back Pain	□ Yes □ No
Flu	□ Yes □ No	Neck Pain	□ Yes □ No
Bloody Noses	□ Yes □ No	Other _____	

Regarding your child today:

Is your child accident prone? □ Yes □ No

Has the child had any falls down steps? □ Yes □ No

Has your child had a scoliosis examination? □ Yes □ No

Has your child ever fallen from heights over 2 feet? □ Yes □ No

Is your child hyperactive? □ Yes □ No

Has your child ever been in a motor vehicle accident? □ Yes □ No

Does your child have a learning disorder? □ Yes □ No

Does your child have sleeping difficulties? □ Yes □ No

Has your child ever been hospitalized or had surgery? □ Yes □ No

Does your child have poor posture? □ Yes □ No

Does your child have any problem associating with friends? □ Yes □ No

Does your child show any signs of nervousness, twitching or excessive talking to themselves? □ Yes □ No

Does your child suffer from:

Allergies □ Yes □ No

Asthma □ Yes □ No

Headaches □ Yes □ No

Earaches □ Yes □ No

Has your child ever had any broken bones or sprain injuries? □ Yes □ No

If you could improve one aspect of your child's health or behavior, what would it be? _____

_____

Is your child on any medication? □ No □ Yes

List Medications: _____

Did your child crawl? □ Yes □ No

PARENT'S GENERAL HEALTH

1 **Check off any of the following symptoms YOU have experienced in the past 6 months:**

□ Low back pain	□ Elbow pain	□ Tension across top of shoulders
□ Pain between shoulder blades	□ Shoulder pain	□ Numbness/ tingling in arms/hands
□ Neck pain	□ Hip pain	□ Numbness/tingling in legs/feet
□ Tension/ Headaches	□ Knee pain	□ Dizziness
□ Tired/Fatigued	□ Ankle/Foot pain	□ Nervous
□ Wrist/Hand pain	□ Ringing in ears	□ Difficulty Sleeping
□ Allergies	□ Digestive problems	□ Weight Trouble

Which of the above is worse? _____

How long have you had it? _____

When it is at its worst, how does it feel? _____

2 **Does this cause you to be:**

□ Moody
□ Irritable
□ Interrupt Sleep
□ Restricted on Daily Activities

3 **Does this affect your work:**

□ Decision Making
□ Poor Attitude
□ Decrease Productivity
□ Exhausted at the end of the day
□ Unable to work long hours

4 Does this affect your life:

□ Lose Patience with Spouse or Children
□ Restricted household Duties
□ Interferes with ability to exercise or participate in sports

If you have checked any of the previous items, then you could be suffering from:

- EXCESSIVE STRESS
- STRUCTURAL MISALIGNMENT
- PINCHED NERVES

CHIROPRACTIC CAN HELP YOU! Chiropractic Doctors gently care for the body, naturally, without drugs. They reduce the subluxations that may be the underlying cause of your health problems.

Authorization for Care

I hereby authorize Active Life Chiropractic to help my overall health through the use of adjustments to my spine and extremities, as found necessary. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I understand that this office does not bill any medical insurance including Medicare on my behalf to pay for any of the service rendered to me. This office does not except Medicare patients, yet if you are eligible for Medicare and desire to be seen by Dr. Smith you can sign a statement that wavers your right to bill Medicare. This means you will be completely responsible for the bills occurred in this office and agree that Medicare will not be billed or held responsible for payment. I agree that I am responsible for all bills incurred in this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand that if I suspend or terminate my care, any fees for services rendered me will become immediately due and payable. In the event a care plan package was purchased at a discount any and all used and unused visits will become adjusted to the standard usual fee. There will be no transfer of visits. No refunds for pre-paid visits where there has been no activity on the account for (6) months. If a remaining balance exists on an active/eligible account, it will be refunded within one (1) month. In the event that I am able to receive a reimbursement through the assignment of my insurance (PIP /L&I only), I hereby authorize those insurance rights and benefits payable directly to the provider for services rendered. It is understood and I agreed to have x-rays taken and that the payments to the doctor for x-rays are for examination and interpretation of x-rays only. The x-ray films will remain the property of this office. They are kept on file where they may be viewed at any time. I agree to the above in its entirety.

Patient/Guardian signature_____Date_____