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New Patient Child Intake

Name:____ Date:________________
(First) (Middle) (Last)

Home Address:_____________________________City:________________St:____Zip:__________

HomePhone:_________________WorkPhone:__________________CellPhone:________________

Student Status: ___FT ___PT Employment Status: ___FT ___PT ___ NA

SSN: __ __ __-__ __-__ __ __ __ Date of Birth: _____/______/________ Sex: __ M __ F

Parent's Names: _____________________________Best Contact Number: _____________________

Emergency Contact: _______________________________________Phone: ____________________

How did you learn about our clinic? ____

Were you referred by anyone? If so, please name: ____

Email Address: ____

May we send you clinic updates? (ie: upcoming seminars, newsletter) ___ yes ___ no

Payment Information

I will be paying today by: ☐ Cash ☐ Check ☐ Credit Card

I authorize NeuroTarget Chiropractic, LLC the release of any medical or other information necessary to process this claim. I request payment of medical benefits from either a government or non-government source to NeuroTarget Chiropractic, LLC. I authorize NeuroTarget Chiropractic, LLC to initiate a complaint to the Insurance Commissioner on my behalf. I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I further understand that I will be legally responsible for all collection costs involved with the collection of this account including court costs, reasonable attorney fees and all other expenses incurred with collections, if I default on this agreement. In addition, if I issue a check that is returned by the bank for non-sufficient funds, I understand I will be charged $30.00 for each returned check. If I choose to use my non-contract insurance company I will be considered a cash patient by NeuroTarget Chiropractic. Payment for professional services are due at the time of service. After paying in full I will receive a receipt with the appropriate billing and diagnosis codes to submit to my insurance company myself by following the directions on the back of my insurance card. My insurance company will reimburse me directly. I certify the information above is true and correct to the best of my knowledge.

Parent Signature: ____ Date: ______________

Chief Complaint – Present Condition

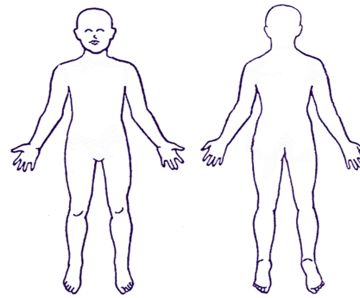
When did the complaint(s) and/or how symptoms begin? ____

Describe the current injury or your current problem: ____

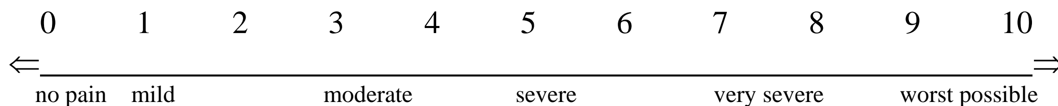
____

Please mark your symptoms on the diagram.

Aching – XXX
Burning - ###
Numbness - ///
Pins/Needles – 000
Stabbing - •••



Rate your pain right now (mark as “N”); worst (mark as “W”); best (mark as “B”)



Please check all present symptoms related to your current condition:

Head & Face

☐ Base of skull ☐ Side/temple ☐ Nausea/vomiting ☐ Ear pain ☐ Throbbing ☐ Migraine
☐ Incapacitating ☐ Front ☐ Ringing in ears ☐ Nose bleeds ☐ Eyelids heavy ☐ Top
☐ Double vision ☐ Pressure ☐ Head feels heavy ☐ Eye pain ☐ Jaw pain ☐ Flushing
☐ Light sensitive ☐ Blurry vision ☐ Headache affects vision ☐ Dizziness ☐ Sinus problems

Neck

☐ Weakness ☐ Spasms ☐ Pain on motion ☐ Limited motion ☐ Pain ☐ Swelling
☐ Lumps ☐ Throat tight ☐ Radiating pain ☐ Difficulty swallowing ☐ Stiffness

Shoulder, Arm & Hand

Shoulder: ☐ Local pain ☐ Limited movement ☐ Pain on movement ☐ Pain from neck ☐ Radiates down arm
Arm & Hand: ☐ Local pain ☐ Pain on movement ☐ Swelling ☐ Cold hands ☐ Weakness
☐ Radiates from neck ☐ Numbness/tingling ☐ Cannot raise arm

Mid-back & Low-back

☐ Weakness ☐ Pain ☐ spasms ☐ Rib pain ☐ Chest pain ☐ Stiffness ☐ Swelling ☐ Pain on motion
☐ Limited motion ☐ Radiating pain

Hips, Legs, Knees and Feet

☐ Local pain ☐ Radiating ☐ From back ☐ Down leg ☐ Swelling ☐ Numbness ☐ Tingling ☐ Spasms
☐ Cramping ☐ Cold feet ☐ Weakness ☐ Pain on motion ☐ Varicose veins

Nerves

☐ Burning ☐ Numbness ☐ Tingling ☐ Tremor ☐ Dizziness ☐ Loss of balance ☐ Loss of consciousness
☐ Coordination ☐ Twitching ☐ Difficulty with memory ☐ Seizures ☐ Generalized weakness

Sleep

☐ Good ☐ Fair ☐ Poor ☐ Poor due to pain ☐ Deep burning pain
☐ Difficulty falling asleep ☐ Difficulty staying asleep ☐ Wake often

Fatigue

☐ Must rest during day ☐ Cannot get enough rest ☐ Intermittent fatigue ☐ Constant fatigue
☐ Worse with exercise ☐ Mental fatigue ☐ Physical fatigue

Current Diagnosis, if any________________________________Date given________________________
Who gave the current diagnosis? _____________________________ Phone_______________________
Criteria used for diagnosis____
Past/Present treatments used____
Does your child have medical records that have been created or has your child seen another doctor because of his/her current condition? Y / N
If so, please list the doctors that have seen your child for his/her current complaint.
1. Name:___________________________________ Phone:_________________________
Address:____

2. Name:___________________________________ Phone:_________________________
Address:____

3. Name:___________________________________ Phone:_________________________
Address:____

Has your child had any diagnostic tests performed by the aforementioned doctors or any other doctors?
Yes / No

If so, please check the tests your child may have had performed.

- ☐ MRI
- ☐ X rays
- ☐ Lab Work
- ☐ Electrodiagnostics
- ☐ Functional Testing
- ☐ Psychological Testing

Other:____

Pregnancy and Development:

Was the pregnancy normal/without complications? Yes / No
(describe):____
____

Duration of the pregnancy ______________ Number of weeks ________ ☐ early ☐ late
Type of delivery: ☐ Vaginal ☐ Breech ☐ Cesarean ☐ Forceps/Extraction
Complications during labor or delivery? Yes / No
(describe):____
____

Newborn difficulties? Yes / No
(describe):____
____

Please indicate the age at which your child achieved the following:

Sat without support	________	Spoke first words	________
Crawled	________	Put 2-3 words together	________
Walked	________	Spoke in sentences	________
Toilet trained	________		

Concerns regarding your child's early development? Yes / No
(describe):____
____

Current Grade Level _______

Has your child had school-related problems in any of the following areas?

Reading (phonics)	☐	Attention/concentration	☐
Reading (comprehension)	☐	Behavior	☐
Spelling	☐	Social skills	☐
Mathematics	☐	Emotions	☐
Handwriting	☐		

Past Health Care History:

Has your child had any previous care (DC, DDS, DO, DPT, MD, ND, OD, PhD)? Yes / No
Please list where and when: ____
____

Has your child ever been hospitalized? Yes / No
If so, where and when?
____
____

Has your child had any previous surgeries? Yes / No If so, please list the date, type, hospital, and result:
____
____

Has your child ever had any major illnesses, injuries, or falls? Yes / No

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Review of Systems:

Head, Ears, Eyes, Nose, and Throat

☐ Vision problems ☐ Eye pain ☐ Hearing difficulty ☐ Dental problems ☐ Headaches
☐ Earache/ infections ☐ Sore throat ☐ Ringing in ears ☐ Sinus congestion

Cardiovascular and Respiratory

☐ Chest pain/tightness ☐ Fainting ☐ Dizziness ☐ Irregular/heartbeat ☐ Cold hands/feet
☐ Lightheaded

Gastrointestinal

☐ Nausea/vomiting ☐ Diarrhea ☐ Constipation ☐ Gas/bloating ☐ Bloody stools
☐ Esophageal reflux ☐ Bowel incontinence ☐ Abdominal pain/cramps

Genitourinary

☐ Pain with urination ☐ Frequent urination ☐ Loss of bladder control
☐ Wake to urinate ☐ Blood in urine ☐ Urgency with urination

Musculoskeletal

☐ Joint pain ☐ Muscle pain ☐ Difficulty w/limb movement
☐ Joint stiffness ☐ Muscle stiffness

Nervous System

☐ Nervousness/anxiety ☐ Dizziness ☐ Seizures/convulsions
☐ Depression ☐ Weakness ☐ Confusion/forgetfulness

General

☐ Weight loss/gain ☐ Skin rash/sores ☐ Night sweats ☐ Excessive thirst ☐ Chills
☐ Fever ☐ Insomnia ☐ Fatigue ☐ Bruise/bleed easily

Is your child taking any medications? Yes / No If yes, please fully complete the chart below.

Medication Name	**Dosage (strength)**	**How often taken**	**How long have you been taking medication**	**Who Prescribed this Medication**	**For Doctor's Use Only**

Are there medications to which your child has had an allergic reaction or unpleasant side-effects? ☐ Yes ☐ No If yes, name.

Medication Name	**Reaction**

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Has your child had an allergic reaction to any of the following?

☐ Latex and rubber ☐ Bee or wasp stings ☐ Adhesive tape ☐ Iodine or x-ray contrast
☐ Influenza vaccination ☐ Other: ___________________________ ☐ None

Does your child have any food allergies? Yes / No If yes, please list________________________________

Is your child currently taking any Supplements? Yes / No If yes, please list:
____
____

FAMILY HEALTH HISTORY

	Patient	Mother	Father	Brothers	Sisters	Grandparents	None
Cancer	☐	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐
Eczema/Psoriasis	☐	☐	☐	☐	☐	☐	☐
Migraine Headache	☐	☐	☐	☐	☐	☐	☐
Seizure Disorder	☐	☐	☐	☐	☐	☐	☐
Stroke/TIA	☐	☐	☐	☐	☐	☐	☐
Abnormal Bleeding	☐	☐	☐	☐	☐	☐	☐
Anemia	☐	☐	☐	☐	☐	☐	☐
Alcohol /Drug Abuse	☐	☐	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐	☐	☐
Other Psych. /Mental Illness	☐	☐	☐	☐	☐	☐	☐
Suicide (or attempted suicide)	☐	☐	☐	☐	☐	☐	☐
Genetic Disorder	☐	☐	☐	☐	☐	☐	☐

If any family member is deceased due to any of the conditions listed above, please list who and of what condition____

What are your expectations or hopes regarding the treatment outcomes? ______________________
____

Do you have any special concerns regarding treatment procedures? ____________________________
____

Upon signature of this document I am certifying that all the information provided is true, correct and complete. If more information about my illness becomes known I will tell the doctor when possible so that it can be added to my record. I also understand that I have read the separate informed consent sheet.

Parent or Guardian Signature______________________________________**Date**_______________