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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 Pietila 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 Pietila Chiropractic, LLC. I authorize Pietila 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 Pietila 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 your complaints and/or symptoms begin? _____

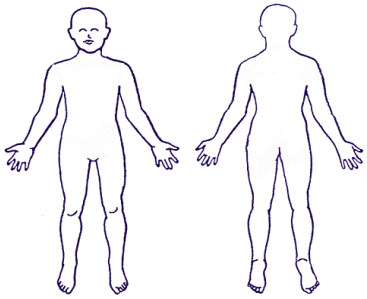
Describe your current injury or your current problem: _____

_____

_____

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")

0 1 2 3 4 5 6 7 8 9 10

⇐_____⇒

no pain mild moderate severe very severe worst possible

Please check all present symptoms related to your <u>current</u> 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

<u>Shoulder</u>: __ local pain __ limited movement __ pain on movement __ pain from neck __ radiates down arm
<u>Arm & Hand</u>: __ 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
__ Ear ache/ infections __ Sore throat __ Ringing in ears __ Sinus congestion

Cardiovascular and Respiratory
__ Chest pain/tightness __ Fainting __ dizziness __ irregular/heartbeat __Cold hands/feet
__ light headed

Gastrointestinal
__ Nausea/Vomiting __ Diarrhea __ Constipation __ Gas/bloating __ Bloody stools
__ esophageal reflux __ bowel incontinence __ Abdominal Pain/Cramps

Genitourinary
__ Pain with Urination __ Loss of bladder control __ Frequent urination
__ 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 __ seizures/convulsions __ dizziness
__ depression __ confusion/forgetfulness __weakness

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 fill 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**

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_____