Initials _____

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PEDIATRIC INTAKE PAPERWORK

Build A Healthy Foundation

Welcome to RISE CHIROPRACTIC!

- Initial the top right corner of each page.
- Complete all questions. (For any question that does not apply to your child, respond "N/A" for Not Applicable.)

1. **Today's Date:** _____
2. **Has your child ever received chiropractic care?** ☐ No ☐ Yes
   (Include doctor's name): _____
3. **Has anyone in your family ever received chiropractic care?** ☐ No ☐ Yes
   (Include family member & doctor's name): _____
4. **Who may we thank for referring you to our office?** _____

PERSONAL INFORMATION

5. **Child's Full Name:** _____ **Child's Preferred Name:** _____
6. **Child's Date of Birth:** _____ **Age:** _____ **Gender:** ☐ Male ☐ Female
7. **Street Address:** _____
8. **City:** _____ **State:** _____ **Zip:** _____

9. **Full Name of Parent / Guardian #1:** _____
10. **Phone:** _____ ☐ Home ☐ Work ☐ Cell, **(Service Provider):** _____
11. **Email:** _____
12. **Occupation:** _____ **Employer:** _____

13. **Full Name of Parent / Guardian #2:** _____
14. **Phone:** _____ ☐ Home ☐ Work ☐ Cell, **(Service Provider):** _____
15. **Email:** _____
16. **Occupation:** _____ **Employer:** _____

17. **What is the relationship between Parent / Guardian #1 & #2:** ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other, **(Explain):** _____
18. **Who is responsible for your child's finances:** ☐ Both Parents / Guardians ☐ Parent / Guardian #1 ☐ Parent / Guardian #2 ☐ Other: _____ **(Other's Phone #):** _____
19. **Name(s) & age(s) of your child's sibling(s):** _____
    _____

HEALTH GOALS

21. **Select the specific areas of your child's life that you'd like to improve.**

☐ Relieve Pain / Discomfort
☐ Improve Posture
☐ Restore Proper Function
☐ Strengthen Immune System
☐ Increase Self Confidence
☐ Improve Focus / Concentration
☐ Improve Mood / Temperament
☐ Increase Energy
☐ Get Adequate Sleep
☐ Drink More Water
☐ Improve Diet / Nutrition
☐ Improve Digestion
☐ Maintain Healthy Body Weight
☐ Improve Athletic Performance
☐ Reduce Medication(s)
☐ Treat Injury: _____
_____
☐ Treat Illness: _____
_____
☐ Other: _____
_____

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If your child is 0 to 5 years of age, complete page 2. If your child is older than 5, skip ahead to page 3.

PRENATAL HISTORY

22. Questions 23-33 are in regards to the prenatal history of your child. Are you the birth mother?
☐ Yes ☐ No, **(Answer the questions to the best of your knowledge).**

23. List the name of the ☐ Doctor / ☐ Midwife: _____

24. Were there any fertility issue(s) or miscarriage(s) prior to the pregnancy?
☐ No ☐ Yes, **(Explain):** _____

_____

25. Did the birth mother receive chiropractic care <u>BEFORE</u> the pregnancy?
☐ No ☐ Yes, **(Explain):** _____Days Before _____Weeks Before _____Months Before _____Years Before

26. Did the birth mother receive chiropractic care <u>DURING</u> the pregnancy?
☐ No ☐ Yes, **(Explain):** Starting at week: _____ of pregnancy through week: _____ of pregnancy.

27. Were any ultrasounds taken during the pregnancy? ☐ No ☐ Yes, **(Include, total number)**: _____

28. Did the birth mother smoke before or during the pregnancy? (Check all that apply)
☐ No ☐ Yes, Before ☐ Yes, During, **(Explain):** _____

29. Did the birth mother drink alcohol during the pregnancy? ☐ No ☐ Yes, **(Explain):** _____

_____

30. Did the birth mother exercise during the pregnancy? ☐ No ☐ Yes, **(Explain):** _____

_____

31. Did the birth mother experience any complications, serious illness, or health emergency during the pregnancy? ☐ No ☐ Yes, **(Explain):** _____

_____

32. List any drug / medication, vitamin / supplement or natural remedy that the birth mother took during the pregnancy: _____

33. Select any stress that the birth mother experienced during the pregnancy. (Check all that apply):

☐ Digestive Issues	☐ Lack of Sleep	☐ Anxiety	☐ Financial Stress
☐ Poor Water Intake	☐ Lack Of Energy	☐ Depression	☐ Occupational Stress
☐ Poor Diet / Nutrition	☐ Slip / Fall / Injury	☐ Mood Swings	☐ Death of A Loved One
☐ Nausea / Morning Sickness	☐ Mandatory Bed Rest	☐ Ankle Swelling	☐ High Blood Pressure

☐ Other: _____

BIRTH HISTORY & INFANCY

34. At how many weeks of pregnancy was your child born? _____Weeks

35. Child's Birth Weight: _____lb. _____oz. **Birth Height:** _____ft. _____in. **APGAR Scores:** _____ - _____

36. Select the location of your child's birth: ☐ Home ☐ Hospital ☐ Birthing Center ☐ Other: _____

37. Select the delivery method of your child's birth:
☐ Vaginal ☐ Vaginal Birth After Cesarean ☐ Planned Cesarean Section ☐ Emergency Cesarean Section

38. Was an intervention or assisted delivery procedure used during the birth of your child?
☐ No ☐ Yes, **(Check all that apply):** ☐ Amniotomy, (breaking the water sac) ☐ Episiotomy, (surgical incision)
☐ Induction, (synthetic labor starting drug) ☐ Epidural Anesthetic ☐ Local Anesthetic ☐ Vacuum Extraction
☐ Forceps ☐ Other: _____

39. List any drug / medication, vitamin / supplement, or natural remedy that the birth mother took for pain management during the labor / delivery of your child: _____

_____

40. What was the birth mother's birthing position? ☐ Back-lying ☐ Side-lying ☐ Kneeling ☐ Squatting
☐ Sitting ☐ Standing ☐ Water Birth, **(Position):** _____ ☐ Other: _____

41. Were there any complications during the labor, delivery, or birth of your child?
☐ No ☐ Yes, **(Explain):** _____

_____

42. Was / is your child breast fed? ☐ No ☐ Yes, **(Explain):** _____Days _____Weeks _____Months _____Years

43. Was / is your child formula fed? ☐ No ☐ Yes, **(Explain):** _____Days _____Weeks _____Months _____Years

44. Was your child introduced to cow's milk? ☐ No ☐ Yes, **(Starting at what age?):** _____

46. According to the National Safety Council, approximately 50% of children fall head first from a high place during their first years of life (i.e. a bed, changing table, down stairs)
Did your child have a fall similar to this? ☐ No ☐ Yes, **(Explain):** _____

_____

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CASE HISTORY & LIFESTYLE

47. Does your child have any genetic disorder or disability? ☐ No ☐ Yes, **(Explain):** _____

_____

48. At what age did your child begin to do the following? Walk: _____ **Speak:** _____

49. Has your child ever had a serious illness or health emergency? ☐ No ☐ Yes, **(Explain, include the year):**

_____

50. Has your child ever had an operation? ☐ No ☐ Yes, **(List all operation(s), include the year):**

_____

51. Has your child ever been in an auto accident? ☐ No ☐ Yes, **(Include the year):** _____

52. Has your child ever been unconscious as a result of an injury, illness, or bodily dysfunction?
☐ No ☐ Yes, **(Explain):** _____

53. Has your child ever fractured a bone? ☐ No ☐ Yes, **(Explain):** _____

54. Does your child have any allergies? ☐ No ☐ Yes, **(Explain):** _____

55. Is your child regularly exposed to secondhand smoke? ☐ No ☐ Yes, **(Explain):** _____

56. Has your child ever taken an antibiotic drug? ☐ No ☐ Yes, **(Approximate date last taken):** _____

57. Has your child received any vaccines? ☐ No ☐ Yes, **(Explain):** ☐ On Schedule ☐ On A Delayed Schedule

58. Is your child taking any over-the-counter / prescription drug, vitamin / supplement or natural remedy?
☐ No ☐ Yes, **(List the name & reason for taking):** _____

_____

59. Does your child have any social, behavioral, or emotional issues? ☐ No ☐ Yes, **(Explain):** _____

_____

60. Does your child have any trouble sleeping? ☐ No ☐ Yes, **(Explain):** _____

_____

61. Select all electronic devices that your child uses on a daily basis, (Include the typical length of use):
☐ Smart Phone: _____ hour(s) ☐ Tablet: _____ hour(s) ☐ Television: _____ hour(s)
☐ Desktop Computer: _____ hour(s) ☐ Laptop Computer: _____ hour(s)

62. Does your child have any digestive issues? ☐ No ☐ Yes, **(Check all that apply):** ☐ Heartburn / GERD
☐ Acid Reflux ☐ Bad Breath ☐ Nausea ☐ Vomiting ☐ Stomach Pain / Cramps ☐ Bloating ☐ Gas ☐ Diarrhea
☐ Constipation ☐ Selective Eater / Picky Eater ☐ Painful Bowel Movements ☐ Foul-Smelling Stool
☐ A Sensitivity To: _____ ☐ A Digestive Disease / Disorder: _____

63. How many days per week does your child typically eat the following types of food?
Fruits:____ Vegetables:____ Meat / Poultry:____ Seafood:____ Eggs:____ Dairy:____ Beans / Legumes:____
Bread / Grains:____ Soy:____ Nuts / Seeds:____ Fats / Oils:____ Artificial Sweeteners / Added Sugars:____
Processed Foods:____ Fried Foods:____ Juices / Sugared Beverages:____ Caffeinated Beverages:____
Breast Milk: ____ Formula: ____ **(Additional Comments):** _____

64. Record your child's current weight & height. Weight: _____lb. _____oz. **Height:** _____ft. _____in.

65. How often does your child exercise? ☐ Never ☐ Occasionally ☐ _____times per week ☐ Daily

66. List your child's regular physical activities? _____

67. List your child's hobbies & interests: _____

CURRENT SYMPTOMS

68. Review the symptoms / conditions listed below and select all that your child currently experiences.

☐ Acid Reflux	☐ Autism Spectrum	☐ Epilepsy	☐ Restless Sleep
☐ ADHD / ADD	☐ Back Pain / Neck Pain	☐ Growing Pains	☐ Scoliosis
☐ Allergies	☐ Bed Wetting	☐ Headaches	☐ Sinus Problems
☐ Anxiety	☐ Colic	☐ Nosebleeds	☐ Skin Problems
☐ Asthma	☐ Digestive Problems	☐ Poor Posture	☐ Tantrums / Temperament
☐ Athletic Injury	☐ Ear Infections	☐ Recurring Colds / Fevers	☐ Other: _____

☐ My child **DOES NOT** have any of the symptoms / conditions listed above. **(If selected, skip ahead to page 4.)**

69. When did your child's symptom(s) begin? _____Years Ago _____Months Ago _____Weeks Ago _____Days Ago

70. Did your child's symptom(s) begin as a result of an injury? ☐ No ☐ Yes, **(Explain):** _____

_____

71. What have you already tried that HAS NOT helped to relieve your child's symptom(s)?

_____

72. What have you already tried that HAS helped to relieve your child's symptom(s)?

_____

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INITIAL ASSESSMENT

73. CHILD'S NAME: _____ **DATE:** _____

74. Select all emotional, physical, and chemical stress that your child has experienced in the past 3 months.

☐ Lack of Sleep
☐ Poor Diet / Nutrition
☐ Poor Water Intake
☐ Slip / Fall
☐ Sports Injury
☐ Increase In Exercise
☐ Decrease In Exercise
☐ Lack Of Energy
☐ Excessive Sitting
☐ Excessive Standing
☐ Anxiety
☐ Depression
☐ Overwhelmed
☐ Academic Stress
☐ Social / Relational Stress
☐ Death of A Loved One
☐ Hospitalization
☐ Surgery / Operation
☐ Increase In Medication
☐ Decrease In Medication
☐ Other: _____

75. Use the following 0 -10 scale of discomfort to answer the remaining questions on this page.

NONE	MILD			MODERATE			LIMITING			SEVERE
0	1	2	3	4	5	6	7	8	9	10
I am free from any symptom. I can do all my daily activities. My quality of life is great.	I barely notice the symptom, but when I do, it causes me some discomfort. I can do most of my daily activities. My quality of life is good.			I notice the symptom and it causes me discomfort. I can only ignore the symptom for a short period of time. I can do some of my daily activities. My quality of life is okay.			I am in constant distress from the symptom. It disrupts my ability to think, work, and maintain social relationships. I can not do many of my daily activities. My quality of life is poor.			I am in excruciating pain from the symptom and it causes me agony. I am ill, delirious, and / or bedridden. I can not do any of my daily activities. My quality of life is miserable.

76. Select which statement is true for your child.

☐ My child **DOES** have symptoms. ☐ My child **DOES NOT** have symptoms. **(If selected, skip ahead to page 5.)**

77. Write your child's main symptom here:

Place an "X" in the box to rate your answer to each question below.	0	1	2	3	4	5	6	7	8	9	10
Rate your child's discomfort from the symptom RIGHT NOW.											
Rate your child's discomfort from the symptom ON AVERAGE.											
Rate how close to "0" your child's discomfort gets AT ITS BEST.											
Rate how close to "10" your child's discomfort gets AT ITS WORST.											

78. If your child has another symptom write it here:

Place an "X" in the box to rate your answer to each question below.	0	1	2	3	4	5	6	7	8	9	10
Rate your child's discomfort from the symptom RIGHT NOW.											
Rate your child's discomfort from the symptom ON AVERAGE.											
Rate how close to "0" your child's discomfort gets AT ITS BEST.											
Rate how close to "10" your child's discomfort gets AT ITS WORST.											

79. If your child has another symptom write it here:

Place an "X" in the box to rate your answer to each question below.	0	1	2	3	4	5	6	7	8	9	10
Rate your child's discomfort from the symptom RIGHT NOW.											
Rate your child's discomfort from the symptom ON AVERAGE.											
Rate how close to "0" your child's discomfort gets AT ITS BEST.											
Rate how close to "10" your child's discomfort gets AT ITS WORST.											

*** If your child has more symptoms, simply ask a team member at the office for another form.**

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If your child is older than 5 years of age, complete page 5. If your child is 0 to 5, skip ahead to page 6.

ACTIVITIES OF DAILY LIVING

80. Use the 0 -10 scale to rate your child's level of discomfort when doing the activities listed below.

- Place an "X" in the box to mark your rating. (Mark the "N/A" box for any activity Not Applicable to your child.)

NONE	MILD			MODERATE			LIMITING			SEVERE
0	1	2	3	4	5	6	7	8	9	10

PERSONAL HYGIENE & DAILY CARE

ACTIVITY	RATING												ADDITIONAL NOTES:
	0	1	2	3	4	5	6	7	8	9	10	N/A	
Bathing / Showering													
Grooming Hair													
Brushing Teeth													
Using The Toilet													
Dressing The Upper Body													
Dressing The Lower Body													

DAILY PHYSICAL ACTIVITIES

ACTIVITY	RATING												ADDITIONAL NOTES:
	0	1	2	3	4	5	6	7	8	9	10	N/A	
Standing													
Walking													
Sitting													
Squatting													
Kneeling													
Reaching Overhead													
Bending Forward													
Turning Left													
Turning Right													
Move From Lying To Sitting													
Move From Sitting To Standing													
Move From Standing To Sitting													

FUNCTIONAL ACTIVITIES

ACTIVITY	RATING												ADDITIONAL NOTES:
	0	1	2	3	4	5	6	7	8	9	10	N/A	
Sleeping													
Eating													
Going Up & Down Stairs													
Getting In & Out Of Car													
Driving													
Using A Computer													
Focusing / Concentrating													
Preparing Food													
Household Chores													
Lifting Children													
Carrying Bag / Purse													

SOCIAL, RECREATIONAL, & OTHER ACTIVITIES

ACTIVITY													ADDITIONAL NOTES:
	0	1	2	3	4	5	6	7	8	9	10	N/A	
Running / Hiking													
Hobbies / Other													

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FAMILY HEALTH HISTORY

81. Place an "X" in the box below to show if your child's family members have ever had the following conditions.

- **If there is more than one family member per category, use an "X" to represent each individual.**
- **If you are helping your child fill out this form, use "SELF" to represent his or her conditions.**

82. Is your child adopted? ☐ No ☐ Yes, **(Complete the "SELF" column below and any other column if applicable.)**

CONDITION	SELF	SIBLING(S)	FATHER	MOTHER
Acid Reflux / Heartburn / GERD				
ADD / ADHD				
Allergies				
Anxiety				
Arthritis / Joint Pain				
Asthma / Difficulty Breathing				
Bed Wetting				
Birth Defect				
Cancer				
Colic				
Convulsions / Epilepsy				
Deceased				
Depression				
Diabetes				
Digestive Problems				
Disc Problems				
Ear Problems / Hearing Loss				
Fibromyalgia / Muscle Pain				
Frequent Cold / Flu				
Gall Bladder Problems				
Headache / Migraines				
Heart Problems				
High / Low Blood Pressure				
HIV / AIDS				
Impotence / Sexual Dysfunction				
Kidney Problems				
Learning Disability				
Liver Problems				
Menstrual Dysfunction				
Mood Changes / Irritable				
Neck Pain / Back Pain				
Prostate Problems				
Sciatica				
Scoliosis				
Sinus / Drainage Problems				
Skin Problems				
Sleep Problems				
Thyroid Problems				
Tremors				
Vertigo / Dizziness				
Vision Problems				
Other:				

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TERMS OF ACCEPTANCE

Here at RISE Chiropractic the term **Practice Member** is used instead of "patient" as "patient" suggests illness or injury, and many whom we serve are healthy and seeking wellness rather than symptom management. A Practice Member is an active participant in his or her chiropractic care, and is therefore invited to ask any questions or express any concerns that he or she may have. Practice Members can expect quality service and leadership from RISE Chiropractic as they regain control of their health. With the utilization of state of the art advanced technology, a complete analysis of your child's spine will be administered first to detect the presence of vertebral subluxation and to monitor your child's progress. Please read and sign this form stating that you understand the items explained below. If there is anything that is unclear please ask questions before you sign. If you refuse to sign this form, the doctor reserves the right to refuse care.

INFORMED CONSENT FOR CHIROPRACTIC CARE

I hereby consent to give the doctor of chiropractic, and anyone working in the RISE Chiropractic office authorized by the chiropractor, permission and authority to care my child **(the minor listed here: _____ for whom I am legally responsible).** Chiropractic tests, diagnosis, analysis, and adjustments are very safe and beneficial and rarely cause any risks. In rare cases, underlying physical defects, deformities or pathologies may make your child prone to injury. It is the responsibility of the child's parent(s) / guardian(s) to make it known, or to learn through health care procedures if your child is suffering from latent pathological defects, illnesses, or deformities, which would otherwise not come to the attention of the chiropractor. The doctor of chiropractic will not give any treatment or care if he or she is aware that such care should not be used for a particular condition or circumstance. Your child's doctor of chiropractic is a licensed primary care provider, and is available to work with all other types of providers. I understand that if my child is accepted as a Practice Member at RISE Chiropractic, I am authorizing them to proceed with any treatment that they deem necessary. I understand that following the doctor's recommended care plan is essential to maximizing my child's healing and reaching optimal health through chiropractic. Furthermore, any questions that I have regarding chiropractic care, will be explained to me upon my request.

AUTHORIZATION FOR X-RAYS

Specific postural x-rays may be necessary for the identification of the location, type, and severity of vertebral subluxation, as well as for the diagnosis and identification of latent or dangerous conditions requiring medical attention. X-rays may also be used to show progress after a period of recommended chiropractic care. At your request, you can receive a copy of your child's x-rays to a disc for the mandated fee of $15.00.

By signing this page below, I authorize RISE Chiropractic to perform diagnostic x-rays of my child except if my female child is pregnant.

83. For your female child, select which statement is true:

☐ My female child **IS NOT** pregnant at this time, to the best of my knowledge.
☐ My female child **IS** pregnant, or I believe that she may be pregnant at this time.
(Therefore I **DO NOT** authorize RISE Chiropractic to perform diagnostic x-rays of my child.)

AUTHORIZATION FOR RELEASE OF INFORMATION & ASSIGNMENT OF BENEFIT

By signing below, I recognize that I am financially responsible for all services rendered to my child regardless of insurance or benefit. I understand that RISE Chiropractic, is a cash-office and that I will have to pay for the full cost for services up front and that I am responsible for submitting any insurance claim to my child's insurance to request reimbursement. I recognize that any health insurance policy is an arrangement between me and my child's insurance carrier. I hereby authorize RISE Chiropractic to release all necessary information concerning my child's health condition to any billing company, insurance company, attorney, and/or adjuster in order to process any claim for reimbursement of charges incurred by my child. In addition I authorize RISE Chiropractic to release any information regarding my child's health condition to other health care providers involved in my care. This assignment will remain in effect until revoked by me in writing. I agree that a photocopy of this form is to be considered as valid as the original. I confirm that all information I have provided is true and correct to the best of my knowledge. I confirm that I have read and fully understand this agreement and authorize RISE Chiropractic to proceed with chiropractic care.

84. SIGNATURE: _____ **DATE:** _____

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NOTICE OF PRIVACY PRACTICES

This notice describes how health information about your child may be used and disclosed and how you can get access to your child's health information and records.

RISE Chiropractic, understands the importance of privacy and we are committed to maintaining the confidentiality of your child's protected health information **(PHI)** in compliance with the Health Insurance Portability and Accountability Act of 1996 **(HIPAA)**. We have developed office policies and procedures that protect your child's personal and health information when used within our office and any devices used to copy or transfer this data. We assure you that your child's information will only be shared as required and only for the purpose of administering your child's case and obtaining payment for services. Be assured that without your permission, your child's health information will not be used for any other purpose.

The following ways are how your child's PHI may be used within our office to provide your child the best care and services possible:

- To provide treatment, obtain payment, and conduct health care operations.
- To schedule appointments and send reminders.
- To communicate with your child's family, friends, and / or caregivers with your authorization.
- As permitted or required by the law.
- For certain activities when the law requires it.

The following describes your rights regarding your child's PHI. You may:

- Request to inspect any copy of your child's records.
- Request to amend incomplete or inaccurate information in your child's records.
- Receive an accounting of certain disclosures of your child's health information.
- Ask for additional privacy protections (although your request may be declined).
- Ask for confidential communications in a particular manner.
- Receive a paper copy of this Notice.
- File a complaint without penalty.

RISE Chiropractic reserves the right to change this privacy policy as allowed by law and to make the new notice apply to health information already received as well as any information received in the future. A copy of our current notice is available upon request. The notice will display the effective date.

If you believe that we have not properly respected the privacy of your child's PHI, you may file a complaint with our office by calling (337) 324-3031, sending a letter to our office address 805 B Albertson Pkwy. Broussard, LA 70518 or by emailing risechirola@gmail.com

By signing below, I confirm that I have received and reviewed this notice and understand how health information about my child may be used and disclosed and how I can get access to my child's health information and records.

85. SIGNATURE: _____ **DATE:** _____

86. Remember to initial the top right corner of each page.

TESTIMONIAL CONSENT

RISE Chiropractic celebrates and displays chiropractic testimonials in our office and on our social media outlets to educate others about the benefits of chiropractic care.

87. Do you authorize RISE Chiropractic to display your child's chiropractic testimonial?

☐ Yes, I **DO**.
☐ No, I **DO NOT**.

BELOW IS FOR OFFICE USE

VISIT NOTES		DR. INITIALS

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