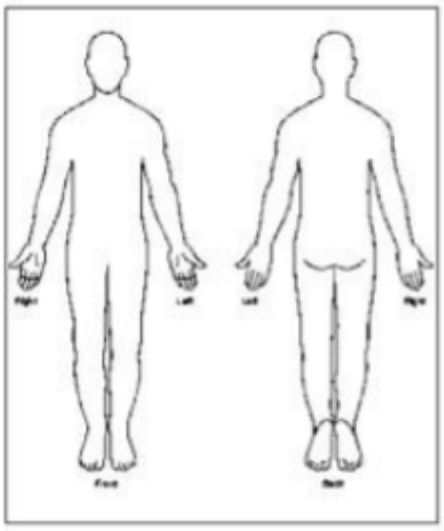
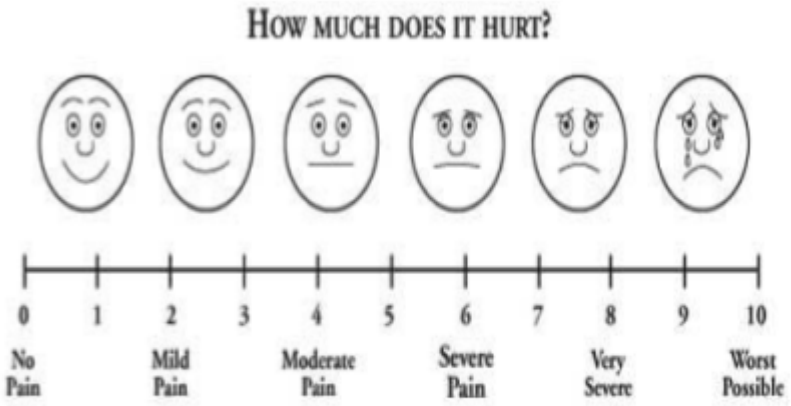
# Cross Timbers Family Chiropractic
# Pediatric Chiropractic Intake Form

Name: _____Date:_____
Address:_____
Sex: Male Female Date of Birth: _____Height:_____Weight: _____
Name of Parents/Guardian:_____
Home Phone:_____Cell Phone: _____Work Phone: _____
*Would you like to receive appointment reminders via text message? Yes___ No___
Email:_____
Authorized Representative/Parent/Guardian: _____Phone: _____
Whom may we thank for referring you?_____

**Reason for visit:** ___Wellness ___Complaint
Present Complaint: _____
When did this begin?_____Was there an accident or injury involved? Y N
Has your child had any past treatment for this complaint? Y N Describe:_____
Current medications: _____

**Please indicate on the picture below where the discomfort is located.**






**General Questions/Prenatal History:**
Any complications during pregnancy? Y N Explain: _____
Medications taken during pregnancy: _____Cigarettes or alcohol during pregnancy: Y N
Birth Intervention: Forceps Vacuum C-Section
Complications during delivery? Y N Explain: _____

Genetic disorders or disabilities:_____
How many times has your child been prescribed antibiotics in the past 6 months? _____
Number of antibiotics in lifetime:_____ Has your child received vaccinations? Y N

**Feeding History:**

Breast Fed: Y N How long: _____
Formula Fed: Y N How long: _____
Introduced to: Solids at _____ Months
Cows milk at _____ Months
Food Allergies or Intolerances: Y N
List:_____

**Childhood Diseases:**

Chicken Pox: Y N Age:_____
Rubella: Y N Age:_____
Rubeola: Y N Age:_____
Mumps: Y N Age:_____
Whooping Cough: Y N Age:_____
Other: _____ Age:_____

According to the National Safety Council, approximately 50% of children fall head first from a high place during their first year of life (ie: a bed, changing table, down stairs, etc).
Was this the case with your child? Y N
Explain:_____
Is/has your child been involved in any high impact or contact type of sports (ie: soccer, football, gymnastics, baseball, cheerleading, martial arts, etc)? Y N
Has your child ever been involved in a car accident? Y N Explain:_____
Other traumas not described above? Y N Explain:_____
Prior surgeries? Y N Explain:_____

**Review of Systems:**

Please check if your child has had any of the following:

| | | | | |
|---|---|---|---|---|
| ___Headache | ___Postural Imbalances | ___Growing Pains | ___Scoliosis | ___Tonsillitis |
| ___Asthma | ___Torticollis | ___Ear Infections | ___Seizures | ___Sleep Problems |
| ___Digestive Problems | ___Bedwetting | ___PDD/Autism | ___ADD/ADHD | ___Frequent Fever |
| ___Colic | ___Learning Difficulties | ___Acid Reflux | ___Hip Dysplasia | ___Allergies |

How would you rate your child's diet?_Well Balanced __Average __High sugar/processed foods
Number of hours your child sleeps: _____hours per night _____ hours per day/naps
Sleep Quality: ____Good ____Fair ____Poor

**********

**Authorization to Treat a Minor**

I, _____ the undersigning parent/guardian having legal custody/guardianship of _____, a minor, do hereby authorize, request and direct Dr. Akin to perform in judgment any examination and chiropractic diagnosis or treatment which is deemed necessary.

Patient:_____ Signature: _____

# Cross Timbers Family Chiropractic

# PATIENT HIPAA ACKNOWLEDGEMENT AND DESIGNATION DISCLOSURE FORM

**I. Acknowledgement of Practice's *Notice of Privacy Practices*:**
By subscribing my name below, I acknowledge that I was provided a copy of the Notice of Privacy Practices (NPP), and that I have read (or had the opportunity to read if I so chose) and understand the Notice of Privacy Practices(NPP) and agree to its terms.

| _____ | _____ | _____ | |
|---|---|---|---|
| **Name of Patient** | **Date of Birth** | **Signature of Patient/Parent/Guardian** | **Date** |

**II. Designation of Certain Relatives, Close Friends and other Caregivers as my Personal Representative:**
I agree that the practice may disclose certain of my health information to a Personal Representative of my choosing, since such a person is involved with my health care or payment relating to my health care. In that case, the Physician Practice will disclose only information that is directly relevant to the person's involvement with my health care or payment relating to my health care.

**Print Name:** _____
**Print Name:**_____
**Print Name:**_____

**III. Request to Receive Confidential Communications by Alternative Means:**
As provided by Privacy Rule Section 164.522(b), I hereby request that the Practice make all communications to me by the alternative means that I have listed below.

**Home Telephone Number:** _____
___OK to leave message with detailed information
___Leave message with call back numbers only

**Written Communication Address:** _____
___OK to mail to address listed above
___E-mail me at_____

**Work Telephone Number:** _____
___OK to leave message with detailed information
___Leave message with call back numbers only

**Fax Communication:** _____
___OK to Fax at the number listed above
___ Email me at_____

**Other:**_____

| _____ | _____ | |
|---|---|---|
| Name of Patient (Print) | Signature | Date |
| _____ | _____ | |
| Witness | Date | |

## *Limited Assignment of Rights and Informed Consent*

I _____, hereby assign any and all legal rights required with respect to the enforcement of medical benefit provisions of any insurance policy under which I qualify for benefits, including the right to proceed in AAA arbitration, necessary to collect monies due and owing to *Cross Timbers Family Chiropractic* for medical services which were provided to me.

This is a limited assignment of rights solely for the purpose of collecting fees for outstanding medical services by *Cross Timbers Family Chiropractic*. I specifically do not assign and thereby reserve all other rights and obligations, including the duty to co-operate with the insurance company, with respect to the enforcement of all other medical benefits coverage.

## *Informed Consent*

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays, on me (or on the patient named below for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future work at the clinic or office listed below or any other office or clinic.

I have had the opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient Signature_____Date:_____

Witness/Guardian Signature _____Date: _____

Dr. Amy Akin / Dr. Joanna Martin/ Dr. Parker Toliver

*Our office will file your insurance as a courtesy to you. Your insurance policy is a contract between you and your insurance company. We are not responsible for policy limitations. During your first visit our office will make every attempt to verify your policy benefits; however this does* ***NOT*** *guarantee your policy or payments. You will be responsible for your deductible and co-insurance.* ***If an insurance payment is anticipated for a service but later denied, you will be responsible for the full amount as soon as our office is notified of the denial.*** *A credit will be added to your account if an insurance payment is received for a service that was already paid for in full by you. You must notify our office of any changes made to your insurance policy or coverage. **A* ***No Show Fee*** *of $25 will be added to your account if your appointment is missed/rescheduled without a 1-hour notice.*