Baker Chiropractic & Acupuncture, LLC
DOWNTOWN KANSAS CITY, MISSOURI

Pediatric Patient Intake
Ages 13 & Under

1100 Main St. Suite 1950 Kansas City, MO 64105
(816) 842-3603

ABOUT THE CHILD

Today's Date:_____

Name:_____ Nickname:_____
Age:_____ Date of Birth:_____ Gender: M___ F___
Height:_____ Weight:_____
Home Address:_____ City:_____ State:_____ Zip:_____
Names and Ages of Siblings:_____
_____

PARENT/GUARDIAN INFORMATION

PARENT A:
Name:_____
Home Phone:_____
Cell Phone:_____
Employer:_____

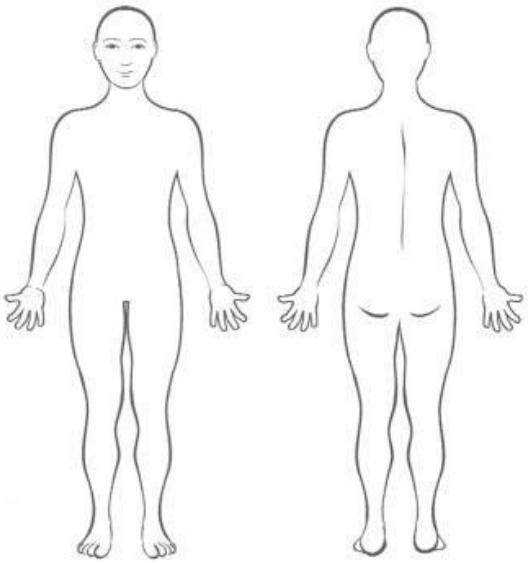
PARENT B:
Name:_____
Home Phone:_____
Cell Phone:_____
Employer:_____

Whom may we thank for referring you to our office?_____

REASON FOR SEEKING CHIROPRACTIC CARE

If your child has no symptoms or complaints, and are here for WELLNESS SERVICES, please check here:_____
What concerns do you feel Baker Chiropractic & Acupuncture can address for your child?_____
_____
_____
Related to: ___Sports ___Auto ___Fall ___Chronic ___Home Injury ___Birth Trauma ___Other_____
When did this condition begin?_____
Has this condition: ___Gotten Worse ___Stays Constant ___Comes and Goes

On the diagram, please show where your child experiences present complaints:



Does this interfere with (please check all that apply):
___School ___Exercise/Sports ___Walking/Mobility
___Sleep ___Attention/Focus ___Communication
___Eating ___Daily Routine ___Playing

Please explain:_____
_____
_____
Has this condition occurred before? ___Yes ___No
Please explain:_____
Has your child seen other doctors for this condition? ___Yes ___No
Doctor's Name:_____
Type of Treatment:_____
Result of Care:_____

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CONFIDENTIAL PATIENT HISTORY FOR:_____ DATE:___/___/___

PREGNANCY, BIRTH AND DEVELOPMENT

During pregnancy, did the mother:
Experience any significant illnesses, difficulties, or trauma? ___Yes ___No
Please explain:_____
Take drugs/medications? ___Yes ___No
Please explain:_____
Smoke or consume alcohol? ___Yes ___No

What type of birth? ___Home Birth ___Birth Center ___Hospital Birth ___Water Birth ___Vaginal ___Caesarean
Was the delivery premature? ___No ___Yes Weeks:_____ Weight:_____
Approximately how long did labor last?_____
Was labor artificially induced? ___No ___Yes
Was it determined that the child was breech or otherwise malpositioned? ___No ___Yes
Please explain:_____
Where any invasive procedures used (amniocentesis, CVS)? ___No ___Yes
Please explain:_____

The birth process can be traumatic to a baby's spine and cause interference to the nervous system. Please check which, if any, of the following were administered during labor and birth.
___Epidural ___Pitocin ___Forceps ___Episiotomy ___Vacuum ___Delivery doctor pulled/twisted baby during delivery
___Medications_____ ___Other_____

Please check all that apply to the baby's status immediately after birth:
___Jaundice ___Respiratory Problems ___Feeding Problems ___Displaced Joints ___Broken Bones:_____
___Other Conditions:_____
What was the baby's APGAR Score?_____
Was the baby breastfed? ___No ___Yes If yes, how long?_____
Was formula introduced? ___No ___Yes If yes, at what age?_____
At what age did you introduce solid foods to the baby?_____

Has your child had any developmental delays with the following milestones (Please check all that apply):
___Responding to sound ___Holding up head ___Following an object ___Sitting unassisted ___Crawling ___Walking
___Speaking ___Other:_____

Does (or did) your child have any of the following (Please check all that apply):
___Difficulty crawling on all fours
___Did not crawl on all fours
___Difficulty using utensils
___Crawled for a short period of time then walked
___Difficulty learning to ride a bike
___Appears Clumsy
___Poor hand-eye coordination
___Never crawled

Number of bowel movements per day:_____ Consistency of stools: ___Firm ___Loose ___Normal

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PHYSICAL STRESS: INFANCY & CHILDHOOD

Please check all that apply to your child and give any necessary details:

___Uncoordinated/Accident prone _____
___Has been hospitalized _____
___Had a severe trauma _____
___Has been in an automobile accident _____
___Has fractured a bone _____
___Has dislocated a joint _____
___Has/had a chronic illness _____
___Has had surgery _____

What physical activities does your child participate in?_____
Does your child engage in hobbies or activities that require prolonged awkward/repetitive posture (Ballet, gymnastics, violin, etc.)? ___No ___Yes If yes, what activities?_____

EMOTIONAL STRESS

Please indicate if your child has ever or is currently experiencing any of the emotional stresses below:

___Academic Pressure ___Bullying
___Lifestyle Change ___Loss of a Pet
___Loss of a Loved One ___Relocation
___Parents' Divorce ___New Sibling

Does your child have difficulty interacting with schoolmates or friends? ___Yes ___No
Have you noticed that your child is nervous, twitches, shakes, or exhibits rocking behavior? ___Yes ___No

HEALTH CARE PRACTITIONER HISTORY

Has your child ever received Chiropractic care? ___Yes ___No Name of D.C:_____
Reason:_____ How long?_____ Date of Last Visit:_____

Have you consulted or do you regularly consult any of the following providers for your child (Please select all that apply):
___Medical Physician ___Naturopath ___Acupuncturist ___Homeopath ___Massage Therapist ___Psychotherapist
___Energy Healer ___Other:_____
Reason:_____
_____

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CHILD'S HEALTH HISTORY

Please check each each of the diseases or conditions that your child has now or has had in the past. While they may seem unrelated to the purpose of the appointment, they can affect the overall diagnosis and course of care for your child.

___Vision Problems
___Headaches
___Sleep Disorders
___Irritability
___Skin Problems
___Breathing Problems
___Asthma
___Hyperactivity
___Bed Wetting
___Constipation

___Ear Problems
___Tubes in the Ears
___Attention Problems
___Frequent Colds
___Colic
___Digestive Problems
___Difficulty Turning Head to One Side
___Latch Problems
___Excessive or Painful Gas
___Pink Eye

___Positional Plagiocephaly
Wore a helmet? ___Yes ___No
How Long?_____
___Other:_____
_____
_____

Please list any surgeries your child has had:_____
Does your child have any allergies?_____
Has your child taken, or currently take, any medications? ___Yes ___No
If yes, please list them here:_____
Is your child currently taking any supplements? ___Yes ___No
If yes, please list them here:_____

Has your child had any vaccinations? ___Yes ___No
Please check the vaccination schedule you follow for your child: ___Standard ___Delayed ___We do not vaccinate
Please check all vaccinations the child has received:

___Hepatitis B
___Rotavirus
___DTaP
___Hib
___Pneumococcal
___Polio

___Influenza
___MMR
___Varicella
___Hepatitis A
___Meningococcal
___HPV

Has your child had an adverse reaction to any medications or vaccinations? ___No ___Yes
If yes, please explain:_____
Has your child been exposed to secondhand smoke? ___Yes ___No
Has your child been on antibiotics? ___Yes ___No If yes, how many times?_____
How would you describe your child's sugar consumption? ___None ___Low ___Moderate ___High

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WELLNESS PROFILE

How frequently does you child eat per day? 1-2 Meals___ 3-4 Meals___ 5-6 Meals___ Snack All Day___
Does your child drink bottled water? ___Yes ___No
Does your child drink soda? ___Yes ___No If yes: ___Regular ___Diet
How frequently does your child take over the counter medication?_____
Please list the over the counter medications your child takes:_____
How does your child spend the majority of their day? ___Seated ___Standing ___Other:_____
How often does your child use a computer or watch TV per day?
___0-30 minutes ___30-60 minutes ___2 hours ___3 hours ___4+ hours
Does your child play outside regularly? ___Yes ___No
Do you believe that your child gets enough physical activity? ___Yes ___No
How many hours per day?_____ Position?_____
How well does your child handle stress?_____

Rate the following on a scale of 1-10 (10 being excellent):
Your child's posture:_____
Your child's sleep:_____
Your child's stress level:_____
Daily positive thinking:_____
Doing things they love:_____

Do you have any comments, concerns, or details regarding the health of your child?

_____
_____
_____
_____
_____
_____
_____
_____

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CONFIDENTIAL PATIENT HISTORY FOR:_____ DATE:___/___/___

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

A signed consent form permits us to use your personal health information within our office for the purposes of treatment, receiving payment, and health care operations of our practice.

It is the policy of this practice to release only the minimum necessary information to any source not directly linked to hands on care and treatment of patients in our office as outlined in the Health Insurance Portability Accountability Act of 1996 (HIPAA). This includes third party payers, insurance companies, etc. In these cases your signed consent form permits us to release only enough information to complete the insurance claim process.

In some cases, patients may wish to have their protected health information released. In those cases if the outside entity can provide necessary information, or the amount of information requested by the patient.

In cases of public health, HIPAA does not protect some information. Where we are required by law to release information to any law enforcement or public health agency, our office will only release the minimum information required by law to any outside entity. In all cases we will follow the most restrictive laws, state or federal, that apply in protecting your medical information.

You, as a patient, have a right to see your medical record during normal office hours.

ADDITIONAL USES OF YOUR HEALTH INFORMATION

Our staff may use your health information to remind you of appointments, send birthday or seasonal greeting cards, mailings, newsletters, information about our practice or other information we feel you may be interested in or may improve your health. We will not release a mailing list to any outside entity for solicitation of business not related to our office.

The Health Insurance Portability Accountability Act of 1996 (HIPAA) requires that we receive your permission before we use the personal information in your medical records for any reason.

This consent form gives us permission to use you Protected Health Information (PHI) to carry out treatment, receive and/or as part of health care operations of our practice.

HIPAA also requires us to have a written notice of our privacy policy describing how medical information about you may be used and disclosed. If you so desire, this written notice is available at the front desk for you to read.

You have the right to revoke, in writing, this consent form at any time, although any services performed prior to the revocation of this consent are covered by this consent.

Patient Name:_____ Date:_____

Parent/Guardian Signature:_____

Restrictions:

You have my permission to share PHI with the following people:

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Right to Revise Privacy Practices: As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our office's policies and practices may be required by changes in federal and state laws and regulations. Upon receipt, we will provide you with the most recent notice on an office visit. The revised polices and practices will be applied to all protected health information we maintain.

Doctor/Staff Signature:_____ Date:_____

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Consent for Treatment

I understand that my outpatient registration, treatment or series of treatments by Baker Chiropractic & Acupuncture, LLC is necessary because of my condition. I voluntarily authorize and consent to the usual examination and treatments ordered by the Doctor and staff, including documentation and recording of history and examination.

Consent for Treatment of a Minor

I (We) being the parent, guardian, or custodians of _____, a minor, the age of _____, do hereby authorize, request and direct the Doctor/staff to preform in his/her judgement and necessary examinations, x-rays and recommended treatment for the condition.

Request for Records

I hereby authorize Baker Chiropractic & Acupuncture, LLC to request any medical records, x-rays, and specialized testing results, including serum and tissue testing results for the purpose of giving a better diagnostic picture. I permit a copy of this authorization to be used in requesting my records from any and all health care facilities, Physicians, and health care providers.

Payment & Insurance Release

I permit a copy of this authorization to be used in place of the original by Baker Chiropractic & Acupuncture, LLC. I authorize release to the Health Care Financing Administration and its agents any information needed to determine these benefits are payable.

I authorize any holder of medical information about me to be released to any of the above named health insurance or their contracted claims paying agents, and all information necessary to determine if these benefits are payable.

I authorize payments of medical benefits to this office.

When I pay by check, I expressly authorize this provider, if my check is dishonored or returned for any reason, to debit my account for the amount of the check plus a processing fee of $25.00 plus any applicable sales tax. The use of a check for payment is my acknowledgement and acceptance of this policy and its terms.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. However, I also understand and agree that all services rendered me are charged directly to me and services rendered me will be immediately due and payable. I further agree and understand this if the need arises, accounts delinquent by 90 days may be placed into legal collection agency. I understand and agree that I am responsible for all court cost, collection agency fees, filing fees and attorney fees that are incurred to collect my debt.

_____ _____
Date Patient Name

_____ _____
Witnessed by: Parent/Guardian Signature

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CONFIDENTIAL PATIENT HISTORY FOR:_____ DATE:___/___/___

Cancellation & No Show Policy

Your appointment time has been reserved specifically for you. We understand that situations arise that require you to cancel your appointment. In the event that you are unable to attend your scheduled appointment, we ask that you contact our office at least 24 hours in advance. This will allow us to offer this appointment to another patient who may need our services. With cancellations made less than 24 hours in advance, we are unable to offer that slot to other patients.

Office appointments that are canceled with less than 24 hours notice may result in the patient being required to pay in full for the missed appointment. Patients who do not come to their scheduled appointment without a call to cancel the appointment will be considered a No Show. Patients who No Show two (2) or more times in a 12 month period may be dismissed from the practice and denied any future appointments. Patients may also be required to pay in full for the No Show appointment.

We understand that circumstances may arise that are out of your control. Our office management will assess the situation and may waive the Cancellation Fee in certain circumstances.

The Cancellation and No Show fees are the sole responsibility of the patient and must be paid in full before scheduling any future appointments for the patient.

In the event that you must cancel and cannot reach the office personnel, please leave a message on our voicemail system or email the office. Our answering machine will note the date and time of your call. No fee will be charged if your call or email is received within the above time frame.

By signing my name below, I acknowledge that I was provided with a copy of the Cancellation and No Show policy and that I have read and understand the Cancellation and No Show Policy and agree to its terms.

_____ _____

Parent/Guardian Signature Date

_____

Patient Name

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PHI & TPO Consent

I hereby give my consent for Baker Chiropractic and Acupuncture, LLC to use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). (The notice of Privacy Practices provides a more complete description of such uses and disclosures.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. Baker Chiropractic & Acupuncture, LLC reserves the right to revise its Notice Of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Baker Chiropractic & Acupuncture, LLC, Privacy Officer, at 1100 Main Street Suite 1950, Kansas City, MO 64105.

With this consent, Baker Chiropractic & Acupuncture, LLC may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders or any calls pertaining to my clinical care. However, our policy is not to leave detailed messages regarding Protected Health Information or anything related to treatment, payment, or healthcare operations.

With this consent, Baker Chiropractic & Acupuncture, LLC may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked "Personal and Confidential."

With this consent, Baker Chiropractic & Acupuncture, LLC may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Baker Chiropractic & Acupuncture, LLC restrict how it uses or discloses my PHI to carry out TPO.

However, the practice is not required to agree to my request restrictions, but it if does, it is bound by this agreement.

By signing this form, I am consenting to Baker Chiropractic & Acupuncture, LLC's use and disclosure of PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Baker Chiropractic & Acupuncture, LLC may decline to provide treatment.

I understand these policies and accept responsibility for payment of my account.

Parent/Guardian Signature:_____ Date:_____

Patient's Printed Name:_____