Infant/Child Intake Form

Today's Date: _____
Patient Name: _____ Sex: ____ Date of Birth:_____
Address: _____ City: _____ State:__Zip:_____
Childs Nickname:_____ Child's SSN:_____
Home Phone:_____
Email:_____
Reason for today's visit: _____
Who may we thank for referring you? _____

Family Information
Mother's Name: _____ Father's Name:_____
Home Phone: _____ Cell: _____ Work: _____
Parent's Marital Status: Married: ___ Single:___ Divorced:___ Widowed:____
List ages of other children in the family: _____
Predominant language of family: _____

Pediatrician Information:
Office:_____
Doctor: _____
Phone number:_____
Do they have any other health care providers? Yes/No
If yes, who? _____

Authorization and Financial Responsibility
I authorize Shelby Chiropractic and Dr. Jennifer D. Smith, DC, MSACN to process my cash, credit and/or check payment for the services provided to me. I also understand payments made by credit card will be charged a processing fee. I understand payment is due in full at the time the services are rendered, unless special payment arrangements have been made ahead of time**. I understand that there will be a $30.00 returned check fee for any returned checks**

Patient Signature: _____ Date: _____

Privacy Policy
Please see the form titled Privacy Policy.
I have received, read, and understand the privacy policies of Shelby Chiropractic.

Patient Signature: _____ Date: _____

_ _

Medical Record Release
I authorize Shelby Chiropractic to release any information in the event my insurance company/attorney requests records or information related to my treatment at your office.

Patient Signature: _____ Date: _____

I authorize Shelby Chiropractic to obtain on my behalf information, including but not limited to, provider chart notes, lab or imaging reports, and copies of films. This information will be used by Shelby Chiropractic for the purpose of diagnosis and case management.

Patient Signature: _____ Date: _____

_ _

Chiropractic Informed Consent
All health care procedures carry some degree of risk. The most common side effect of spinal manipulation is short-term muscle soreness. More serious side effects can include bone fractures, muscle strain, ligament sprain, and joint dislocation. Some manipulations of the upper spine have been associated with injury to the arteries in the neck, which could contribute to stoke. However, documented cases are exceedingly rare, and it has been estimated by researchers that the probability of a spinal adjustment causing a stroke is one in several million, and is equal to the risk of going to your primary care physician with the complaint of neck pain. As for chiropractic therapies other than spinal manipulation, the risks are also very slight but can include skin irritation or burns. Compared to other forms of health care, chiropractic is extremely safe, and complications are generally rare.
My doctor has responded to all of my requests for information about the proposed treatment. I have read, and understand the above consent. I have also had the opportunity to ask question about its content. By signing below I consent to the chiropractic treatment.

Patient Signature: _____ Date: _____

_ _

Consent to Treat a Minor
I, _____ (parent/guardian) give my permission to the providers at Shelby Chiropractic to give spinal adjustment/manipulations and necessary therapies to _____ (child's name).

Parent/Guardian Signature: _____ Date: _____

Our Privacy Pledge

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health care information.

- We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment services.
- We may need to use your health information within our practice for quality control or other operational purposes.

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before your sign that consent form (§ 164.520). We reserve the right to Change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment or by mail. Please feel free to call us at anytime for a copy of our privacy notices.

Your right to limit uses or disclosures

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restrictions are binding with us.

Your right to revoke your authorization

You may revoke your consent to us at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we already released you health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

I have read your consent policy and agree to its terms. I am acknowledging that I have received a copy of this notice.

Infant/Child Assessment Form

What is the purpose for visit today? _____

Other Doctors Seen for this Condition: Y N

Doctor's Name(s) and Treatments: _____

Birth History

Were there any problems during pregnancy? Y N
If yes, please explain:_____
_____

Did you take any medications while pregnant? Y N
If yes, please explain:_____
_____

Did you consume any drugs/ alcohol/ cigarettes during pregnancy? Y N
If yes, please explain:_____
_____

Place of Birth: Home____ Birthing Center____ Hospital____

Type of Birth: C-Section____ Vaginal____

Was Labor Induced: Yes____ No_____

Was Anesthesia used: Yes____ No _____

Was there any notable Doctor assisted Birth trauma? Twisting or Pulling ____ Vacuum Extraction_____ Forceps_____
Other_____

Were there any special medical procedures, tests and/or complications? Yes_____ No _____ If yes, please list:
_____
_____

Does the child have any genetic disorders or disabilities? Y N
If yes, please explain:_____
_____

APAGR: _____ Birth weight: _____ Length:_____

Current weight:_____ Length:_____

Has this Child had any previous chiropractic care? Y N Date: _____

Nutrition/Diet

□ Yes □ No Is your child still being breast fed? If no, for how long was he/she breast fed?_____
If still breast feeding. How much cow's milk does the mother consume each day? _____
□ Yes □ No Is your child formula fed? If yes, which formula or other milk is used? _____
□ Yes □ No Is your child eating solid food?
What foods does his/her diet contain? _____
What is your child's favorite food? _____
□ Yes □ No Does your child have any feeding difficulties?
□ Yes □ No Does your child have any food allergies?
□ Yes □ No Does your child have any persistent or intermittently occurring skin rashes
□ Yes □ No Is your child receiving any vitamin supplements?

Medical History

According to the National Safety Council, over 50% of all infants fall from a place 4ft or higher during their first 2 years of life. Can you recall ANY jolts, fall or trauma to this child? Yes_____ No_____ If yes, please describe:

_____

Prior Surgery? Y N -If yes, please list along with date: _____

_____

Has this child experienced any fractures or dislocations? Yes_____ No_____ Please describe: _____

_____

Please ***circle*** any of the following conditions your child has experienced:

Colic	Irregular Sleeping Patterns	Nightmares	Seizures	Tantrums
Ear Infections	Allergies	Asthma	Headaches	Poor Digestion
Repeated Infections or colds	Bed Wetting	Learning Disorders	Emotional Concerns	ADD
Scoliosis	Fevers	Growing/Back pains	Car Accident	ADHA
Concentration Problems	OCD	School/Academic Concerns	Social Concerns	Other:_____

Please list any medications your child has been treated with: _____

_____

Does your child participate in any activities? If yes, please list: _____

_____

Have you chosen to vaccinate your child? ___ Yes ____No

If yes, check all that your child has received.

____DPT ____MMR _____Chicken Pox _____Hepatitis ____Flu _____Roto Virus _____Other

Describe any and all reactions to vaccine(s)._____

Growth and Development (Check all that apply)

Gross Motor Skills

□ Able to hold head up (Age:_____)
□ Head and shoulder can be supported by the forearms
□ Infant can be pulled up into a sitting position by the hands
□ Sits unsupported in the upright position (Age:_____)
□ Head and shoulder can be supported by the arms
□ Rolls from prone to supine (Age:_____)
□ Crawls (Age:_____)
□ Stands holding on to furniture
□ Walks with someone holding onto hand
□ Walks unassisted (Age:_____)
□ Runs
□ Negotiates stairs placing two feet on each step
□ Climbs stairs using on foot on each step
□ Walks down stairs with one foot on each step
□ Hops on one foot

Social Skills

□ Smiles
□ Reaches for familiar objects
□ Plays with hands
□ Plays with feet
□ Clearly shows joy and pleasure
□ Feeds self with fingers
□ Plays peek-a-boo
□ Understands yes and no

Fine Motor Skills

□ Primitive grasp reflex present
□ Holds and shakes a rattle placed in the hand
□ Grasps objects independently
□ Moves an object from one hand to the other
□ Self-feeding, can hold and each a cookie
□ Checks objects by placing them in mouth
□ Picks up object with thumb and index finger
□ Turns 2 to 3 pages of a book at a time
□ Turns pages of a book one at a time
□ Builds a tower containing at least 5 blocks
□ Builds a tower containing at least 10 blocks

Communication Skills

□ Makes cooing sounds
□ Laughs
□ Uses one syllable words such as "Da"
□ Uses two syllable words such a "Mama"
□ Uses 2 to 3 word vocabulary
□ Uses 2 to 3 word phrases

Adaptive Skills

□ Feeds from a cup unassisted
□ Holds own bottle
□ Feeds self with utensils
□ Able to identify and match same colors
□ Copies a circle
□ Copies a cross

□ Yes □ No Do you have any concerns about your child's growth and development?_____
_____
_____
_____

Parent's Chiropractic History

Have you personally been adjusted by a Chiropractor before? Y N

Reason for those visits? _____

Approximate date of last visit _____ Has any other member of your family seen a Chiropractor? Y N

Any other additional information that was not included within the form, feel free to include below:

Patient Signature: _____ **Date:** _____