WILLIAMSTON WELLNESS, PLLC
PEDIATRIC PATIENT INTAKE FORM

Today's Date _____

PATIENT NFORMATION:

Name_____Age_____Date of Birth____/____/____ Gender (circle) M F T

Home Address_____City_____State_____Zip_____

PARENT/GUARDIAN A:

Name _____

Cell Phone _____

Alt Phone _____

Employer_____

E-mail _____

PARENT/GUARDIAN B:

Name_____

Cell Phone _____

Alt Phone _____

Employer _____

PARENT "A" will only receive the appointment reminders.

Ok to receive appointment reminders via ☐ text ☐ email ☐ both ☐ Neither, I prefer a phone call.

Emergency Contact:_____Phone_____

INSURANCE & PAYMENT INORMATION:

Please indicate your method of payment: ☐ Insurance ☐ No Insurance – cash ☐ Health Savings Account (HSA)

Primary Health Insurance Company Name_____

ID/Policy #_____ Group _____ Phone#_____

Policy Holder's Name_____ SSN_____ Birthdate ____/____/____

Secondary/supplemental Health Insurance Company Name_____

ID/Policy #_____ Group _____ Phone#_____

Policy Holder's Name_____ SSN_____ Birthdate ____/____/____

GOALS/REASON FOR VISIT:

Please tell us what your goals & expectations are for your child's visit at Williamston Wellness_____

_____

How did you hear of us? If by referral, please list name_____

Past Chiro Care? ☐ Yes ☐ No For what?_____

Office/Chiro Name _____Last seen_____Good Results? ☐ Yes ☐ No

Primary Doctor Name_____Last Seen_____Phone:_____

Is your child here due to any injury? ☐ Yes ☐ No If yes, when did the injury happen?_____

Please describe what happened _____

Is this an auto related injury? ☐ Yes ☐ No If yes, has it been reported? ☐ Yes ☐ No

If you are here due to an auto accident, please ask receptionist for the proper paperwork. Thank you.

GENERAL HEALTH/PRENATAL HISTORY:

Current Height:_____Weight:_____How would you rate your child's overall health? ☐ Excellent ☐ Good ☐ Poor

Was your child's birth: ☐ Vaginal ☐ C-Section (emergency / planned) Were there any complications during delivery?

☐ Yes ☐ No If Yes, explain: _____

PLEASE CHECK ALL THAT APPLY TO YOUR CHILD AND GIVE ANY NECESSARY DETAILS:

☐ Uncoordinated/Accident prone_____

☐ Has been hospitalized._____

☐ Had a severe trauma. _____

☐ Been in an automobile accident. _____

☐ Has fractured a bone or dislocated a joint_____

☐ Has a chronic illness_____

☐ Has had surgery._____

☐ Has allergies._____

HAS YOUR CHILD EVER SUFFERED FROM ANY OF THE FOLLOWING TRAUMAS:

☐Fall from crib/high chair ☐Fall down stairs ☐Fall off bicycle ☐Fall off playground equipment ☐Other_____

What physical activities does your child participate in? _____

How many times has your child been prescribed antibiotics in the past 6 months? _____ Total during lifetime:_____

Has your child received all recommended vaccinations? ☐ Yes ☐ No If no, explain_____

Please list any medications or supplements your child is currently taking or has taken in the past 6 months.

_____

_____

DIET: How would you rate your child's diet? ☐ Well Balanced ☐ Average ☐ High sugar/processed foods

SODA: How many cans consumed/day?_____ SCREEN TIME (TV, Gaming, etc.): How many hours/day?_____

SLEEP: Number of hours your child sleeps per night _____ Sleeping position? ☐Side ☐ Stomach ☐ Back ☐ Combo

SLEEP QUALITY: ☐ Excellent ☐ Good ☐ Fair Does your child snore? ☐ Yes ☐ No

Type of mattress (foam, coil, water etc..)_____How old?_____

Type of pillow? ☐Foam ☐Feather ☐Other _____ How many? _____How old? _____

Does your child wear a back pack? ☐ Yes ☐ No Does he/she use both straps? ☐ Yes ☐ No Approx. weight:_____

Does your child show excessive or uneven shoe wearing out? ☐ Yes ☐ No

Is your child exposed to second hand smoke? ☐ Yes ☐ No

PLEASE CHECK ALL THAT APPLY TO YOUR CHILD:

☐ Growing pains	☐ Torticollis/head tilt	☐ Tip-toe walking	☐ Sleep Problems	☐ Autism	☐ Bedwetting
☐ ADD/ADHD	☐ Digestive problems	☐ Bleeding Disorder	☐ Scoliosis	☐ Colic	☐ Allergies
☐ Chronic Colds	☐ Reoccurring fevers	☐ Seizures	☐ Ear Infections	☐ Headaches	☐ _____

SYSTEMS REVIEW- Please mark any symptom your child has had in the past 6 months

Genito-Urinary

☐ Back pain ☐ Blood in Urine ☐ Cloudy Urine ☐ Discolored urine ☐ Excessive urination ☐ Incontinence
☐ Kidney Stones ☐ Painful urination ☐ STD

Nervous System

☐ Confusion/Forgetfulness ☐ Fainting ☐ Convulsions ☐ Depression ☐ Headaches ☐ Tingling ☐ Vertigo
☐ Numbness/Paralysis ☐ Trembling ☐ Muscle spasms ☐ Seizures ☐ Weak Grip ☐ Difficulty of speech

Eyes/Ears/Nose/Throat

☐ Lack of smell ☐ Earache/infection ☐ Ear Ringing/noises ☐ Ear Pain ☐ Eye Strain ☐ Sores/ulcers
☐ Nose Bleeds ☐ Trouble swallowing ☐ Sinusitis/hay fever ☐ Tonsillitis ☐ Sore Throats ☐ Hoarseness
☐ Speech difficulty ☐ Visual Disturbances ☐ Pain behind eyes ☐ TMJ ☐ Enlarged thyroid/lump in throat

Gastro-Intestinal

☐ Belching/Gas (excessive) ☐ Nausea ☐ Constipation ☐ Bloody or Black Stool ☐ Diarrhea
☐ Heartburn/acid reflux ☐ Ulcer ☐ Abdominal Pain ☐ Excessive Hunger ☐ Liver disease
☐ Gallbladder Problems ☐ Vomiting ☐ Excessive Thirst ☐ Rapid Weight Gain/Loss ☐ Colitis

Cardio-Vascular

☐ Heart attack ☐ Heart Murmur ☐ High BP ☐ Coughing Blood ☐ Coughing Phlegm
☐ Rapid heart rate ☐ Persistent Cough ☐ Low BP ☐ Irregular Heart Rate ☐ Pain over heart
☐ Lung Problems ☐ Difficulty breathing ☐ Chest pain ☐ Varicose Veins ☐ Asthma/wheezing
☐ Poor Circulation ☐ High Cholesterol ☐ Trouble Sleeping ☐ Blood Clot ☐ Bleeding Disorder

Musculoskeletal

☐ Back pain ☐ Hip pain ☐ Foot/Ankle pain ☐ Muscle pain ☐ Joint swelling ☐ Dislocated joint
☐ Neck pain ☐ Low back pain ☐ Wrist/hand pain ☐ Muscle weakness ☐ Joint stiffness ☐ Osteoporosis
☐ Knee pain ☐ Shoulder pain ☐ Fractures ☐ Muscle cramps ☐ Joint pain ☐ Spine curvature
☐ Arm pain ☐ Leg pain ☐ Sprains/Strains ☐ Muscle twitching ☐ Hot joints ☐ MS

Skin/Hair

☐ Bruise Easily ☐ Sensitive Skin ☐ Dermatitis/Rash ☐ Hives ☐ Itching ☐ Eczema
☐ Sores /Boils ☐ Hair Changes ☐ Nail bed changes ☐ Dryness ☐ Allergies_____

FEMALES ONLY

Has she started menses ? ☐ Yes ☐ No If yes, at what age?_____ Date of last period?_____

FAMILY HEALTH HISTORY	**Myself**	**Mother**	**Father**	**Sibling**	**Grandparent**
Arthritis	☐	☐	☐	☐	☐
Autoimmune Disease *Type:*	☐	☐	☐	☐	☐
Cancer *Type:*	☐	☐	☐	☐	☐
Depression/Mental health	☐	☐	☐	☐	☐
Diabetes *Type:*	☐	☐	☐	☐	☐
Epilepsy/Seizures	☐	☐	☐	☐	☐
Fibromyalgia	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐
Joint Degeneration	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐
Lung Disease/Asthma	☐	☐	☐	☐	☐
Migraines	☐	☐	☐	☐	☐
Osteoporosis/Osteopenia	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐
Thyroid Problems	☐	☐	☐	☐	☐

SYMPTOM SURVEY: Please list problems from most severe to least severe. Please be as specific as possible.

Symptom #1:_____

Location of Pain:_____Severity of Pain _____(scale of 1-10, 10 being the worst pain)

Progression: ☐ Same ☐ Better ☐Worse How often is the pain present? ☐Constant ☐ 50-75% ☐25-50% ☐ <25%

When did the problem begin?_____What do you think caused it?_____

Pain is reduced with: ☐ Rest ☐ Ice ☐Heat ☐ Stretching ☐ Exercise ☐ Pain relievers ☐ Topical creams

Pain is worse with: ☐ Sitting ☐ Standing ☐ Walking ☐Bending ☐ Twisting ☐ Lifting ☐ _____

Description of pain: ☐ Sharp ☐ Shooting ☐ Dull ☐ Achy ☐Burning ☐ Stiff ☐Stabbing ☐Throbbing ☐ Numb

Does your pain radiate? ☐ Yes ☐ No If yes, where?_____

What time of day is your pain the worse? ☐ Morning ☐ Afternoon ☐ Evening ☐ During Sleep ☐ _____

Any prior treatment for this symptom? ☐ Medication ☐ PT ☐ Surgery ☐ Chiro ☐ _____Helpful? ☐ Yes ☐ No

Symptom #2:_____

Location of Pain:_____Severity of Pain _____(scale of 1-10, 10 being the worst pain)

Progression: ☐ Same ☐ Better ☐Worse How often is the pain present? ☐Constant ☐ 50-75% ☐25-50% ☐ <25%

When did the problem begin?_____What do you think caused it?_____

Pain is reduced with: ☐ Rest ☐ Ice ☐Heat ☐ Stretching ☐ Exercise ☐ Pain relievers ☐ Topical creams

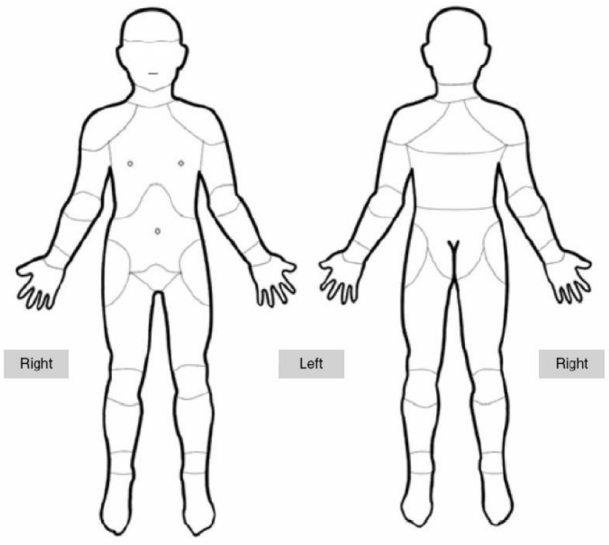
Pain is worse with: ☐ Sitting ☐ Standing ☐ Walking ☐Bending ☐ Twisting ☐ Lifting ☐ _____

Description of pain: ☐ Sharp ☐ Shooting ☐ Dull ☐ Achy ☐Burning ☐ Stiff ☐Stabbing ☐Throbbing ☐ Numb

Does your pain radiate? ☐ Yes ☐ No If yes, where?_____

What time of day is your pain the worse? ☐ Morning ☐ Afternoon ☐ Evening ☐ During Sleep ☐ _____

Any prior treatment for this symptom? ☐ Medication ☐ PT ☐ Surgery ☐ Chiro ☐ _____Helpful? ☐ Yes ☐ No



Please circle any areas of pain or discomfort on diagram and list any additional symptoms or comments:_____

GENERAL/FINANCIAL CONSENT:

On behalf of any patient for whom you are the parent or legal guardian, you agree to the following

- Certify that the information on this form is complete and accurate and that you will promptly notify our office of any changes.
- Assign to Williamston Wellness, any healthcare insurance or reimbursement benefits to which you are entitled to for the care provided by Williamston Wellness and authorize their payment directly to Williamston Wellness.
- Agree to be responsible for all charges owed to Williamston Wellness that are not covered by insurance and acknowledge that you are financially responsible for all charges regardless of any applicable insurance or benefit payments.
- If you are unable to keep a scheduled appointment, you agree to notify us no later than 24 hours before the scheduled time so that we may offer that appointment time to another patient. If proper notice is not given, a fee of $25 per half hour (based on scheduled appointment duration), may be billed starting with the 2nd no show/no call missed appointment.

Parent Name_____ Signature_____ Date_____

INFORMED CONSENT:

I understand, as with any health care procedures, that there are certain complications, which may arise during chiropractic treatments. Those complications include, but are not limited to: fractures, disc injuries, dislocations, muscle strain, Homers' syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to complications including stroke. I do not expect the doctor to be able to anticipate all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure(s) which the doctor feels at the time, based upon the facts then known, that are in my best interest. I have had an opportunity to discuss the nature, purpose and risks of chiropractic treatments and other recommended procedures. I have had my questions answered to my satisfaction. I also understand that specific results are not guaranteed.

I have read (or have had read to me) the above explanation of the chiropractic treatments. I state that I have been informed and weighed the risks involved in chiropractic treatment at this health care office. I have decided that it is in my child's best interest to receive chiropractic treatment. I hereby give my consent to that treatment. I intend for this consent to cover the entire course of treatment for my child's present condition(s) and for any future conditions(s) for which treatment is sought.

Parent Name_____ Signature_____ Date_____

AUTHORIZATION TO TREAT A MINOR:

I, _____, the undersigning parent/guardian have legal custody of _____

_____ (minor patient's name), and do hereby authorize Williamston Wellness, Pllc and it's doctors to perform in judgment, any examination and chiropractic treatment, which is deemed necessary.

Parent Name_____ Signature_____ Date_____

HIPPA ACKNOWLEDGEMENT:

I have reviewed the notice of privacy practices (HIPPA) and have been provided an opportunity to discuss my right to privacy. Upon request I will be given a copy of the Williamston Wellness Privacy Practices.

Parent Name_____ Signature_____ Date_____