Pediatric Intake

Information contained within this form is considered strictly confidential. Your responses are important to help us better understand your child's health, goals of treatment, and ensure the delivery of the best possible care and support. This form must be fully completed before your child can begin your care in our office.

Given Name :_____Nickname: _____
Gender identity/pronouns: _____ Date of birth: _____ Age: _____
Address: _____
City: _____ State: _____Zip:_____
Primary phone: _____ Primary care provider: _____
Legal Guardian's Names:_____
Who lives with you (list names, ages & relationship to child)? _____
_____
_____

May we leave you voicemails about your appointments? _____
Do you prefer to be contacted via phone, text or email? _____
How did you hear about our office? _____

Emergency Contact
Given Name (first, last): _____
Gender identity/pronouns: _____ Date of birth: _____ Age: _____
Cell phone: _____ Email address: _____
Relationship to child: _____

Insurance Information
Insurance company and plan name: _____
Name of policy holder: _____
Relationship to policy holder:_____
Policy holder date of birth (mm/dd/yyyy): _____
ID number: _____ Group number: _____
Who is responsible for your child's bill?_____

Please list any other providers you are working with:
Speech Therapist: _____ Psychologist: _____
Craniosacral Therapist: _____ Occupational Therapist: _____
Physical Therapist: _____Other:_____

Describe the reason for your child's visit today:
_____
_____
_____

Please list any specific goals you may have for care in our office
1._____
2._____
3._____

Developmental History
Do you have any concerns about your child's development?
_____
_____

Please check if your child has reached each developmental milestone and the approximate age (if known)

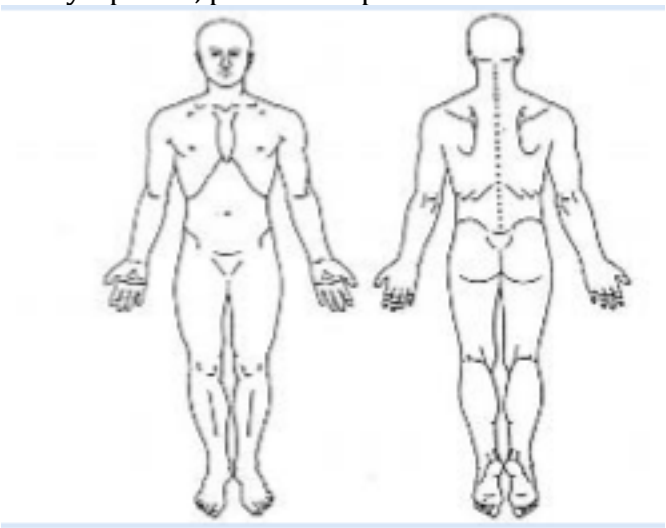
□ roll front to back	age:_____	any concerns? _____
□ roll back to front	age:_____	any concerns? _____
□ sitting unassisted	age:_____	any concerns? _____
□ crawling	age:_____	any concerns? _____
□ creeping	age:_____	any concerns? _____
□ standing unassisted	age:_____	any concerns? _____
□ walking	age:_____	any concerns? _____

Birth History
□planned hospital birth □planned home birth □unplanned home birth
□home birth transfer to hospital □birth center

Delivery
born at _____weeks gestation total length of labor:_____ pushing:_____minutes/hours
□ vaginal □planned c-section □unplanned c-section □vaccum extraction
□forceps delivery □induced ___ weeks □ NICU _____days/weeks
□complications following birth: _____
_____

Musculoskeletal History
If your child is experiencing any pain or neurological symptoms, please complete this section.

Please mark your symptoms on the diagram.



On a scale of 1(not intense) to 10 (you are unconscious with pain), how would you rate your symptoms:

1 2 3 4 5 6 7 8 9 10

When did your symptoms start? _____
How did your symptoms begin? _____
How often do you experience symptoms? Constantly Frequently Occasionally Intermittently
Describe your symptoms? Sharp Dull ache Numbing Burning Tingling Shooting
Other:_____
Are your symptoms? Getting better Staying the same Getting worse
What aggravates your current symptoms? _____
What positions or activities relieve your current symptoms? _____
Have you experienced these symptoms in the past? _____
How do your symptoms interfere with your daily life? _____

Have you seen a chiropractor before? _____ If yes, Doctor's name: _____
How long since last chiropractic adjustment? _____
Have you seen any other health care provider for these symptoms? _____

Current Health History
What is your child's general state of health? _____
How many hours/day is your child physically active? _____
How much screen time does your child have per day or week? _____
Do your child follow a specific diet? _____
Allergies:_____

Does your child have a history of: □upper respiratory infections □asthma □chronic ear infections
□tongue tie □lip tie were ties released? _____ where? _____

Vaccination status: □fully vaccinated □delayed vaccine schedule □not vaccinated

Please list any conditions your child has been diagnosed with and the name of the medical provider who diagnosed it. State the year of diagnosis, and any treatment received or ongoing treatment:
_____
_____
_____
_____
_____
_____

Surgeries and/or hospitalizations (list dates, reasons, and any complications):
_____
_____
_____

Does your child have any implants/pins/screws? _____
Does your child wear arch supports/heel lifts/orthotics/other supportive devices?
_____

Current Medications (including over the counter):

Medication Name	Purpose
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____

Current Herbs/Supplements/Vitamins:
_____
_____
_____

Family History: list any significant family history for your immediate family (parents, siblings, kids)

_____

_____

_____

Please add any other comments, thoughts, or questions you would like me to address.

_____

_____

_____

Required Signatures

□ I authorize use of these intake forms on all of my insurance submissions.
□ I authorize release of information to my insurance companies.
□ I understand that I am responsible for my bill.
□ I authorize my doctor to receive payment for services rendered from my insurance company.
□ I understand that there may be charges that my insurance company may not cover.
□ I understand that copays are due at time of service and that Dr. Persoleo's Office will bill me for any co-insurance or balance owed.
□ I certify that the information on all of my intake forms is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Patient Signature:_____ Date:_____

Missed Appointment/Cancellation Policy

We understand that you may sometimes need to reschedule appointments. If you need to reschedule, please contact our office as soon as you know that you will not be able to keep the appointment. It is our office policy to **require 24 hours advance notice** for all appointment cancellations/reschedules to allow maximum availability for our patients. We welcome voicemails and emails left after hours. If you miss an appointment or cancel it with less than 24 hours notice, a missed appointment fee of $25.00 will be assessed to your account. This fee is not reimbursable by insurance and is the patients' responsibility. There is no fee for weather related cancellations.

Signature:_____ Date:_____

Informed Consent

To the patient: Please ask questions before you sign if there is anything that is unclear.

As with any healthcare procedure, there are certain complications that may arise during chiropractic adjustments and therapy. Complications may include: stiffness and soreness following the first few days of treatment, fractures, disc injuries, dislocations, muscle strain, 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 serious complications including stroke.

The risks of complications due to chiropractic treatment have been described as "rare", about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke, has been estimated at one in one million to one in twenty million, and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered "rare". We will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to our attention, it is your responsibility to inform us.

I _____ understand the above information and consent to chiropractic care in this office under Drs. Michael and Abby Persoleo.

Signature: _____ Date: _____

For Office Use Only:

History:

Findings:

Recommended treatment plan:

Today's treatment:

Homecare:

Provider Signature: _____

Date: _____