ADOLESCENT INTAKE FORM

Kavanagh Chiropractic

Date: _____

Biographical Data

Patient Name: _____

Sex: M / F Date of Birth: _____ Age: _____

Address: _____ City/State/Zip: _____

Mother: _____ Occupation: _____

Address: _____ Phone: _____

Father: _____ Occupation: _____

Address: _____ Phone: _____

Siblings & Ages: _____

How did you hear about our office? _____

Emergency Contact

Name: _____ Relationship to patient: _____

Home Phone: _____ Cell Phone: _____

Family Doctor

Clinic Name: _____ Doctor's Name: _____

Other Health Care Professionals

(Medical Specialist, Physical Therapist, Occupational Therapist, Naturopathic Doctor, etc.)

Name & Title: _____

Date & reason for last visit: _____

Name & Title: _____

Date & reason for last visit: _____

Why have you decided to have your child evaluated by a Chiropractor?

- ☐ He/She is continuing ongoing care from another chiropractor
- ☐ I recently visited a chiropractor and am interested in having my child evaluated
- ☐ I have concerns about his/her health and I'm looking for answers
- ☐ He/She has a specific condition that I've learned chiropractic may be able to help
- ☐ I want to improve my child's immune function

AUTHORIZATION TO RELEASE INFORMATION

Please read thoroughly, ***initial at each section*** and ***sign at the bottom***. Thank you.

HIPAA/Privacy Notices

Our Privacy Pledge: Kavanagh Chiropractic is concerned with and committed to the protection of our patient's privacy and ensuring the confidentiality of personal health information entrusted to us. Ways in which Kavanagh Chiropractic may disclose your health information, including but not limited to: treatment, diagnosis, 3rd party payor, billing, appointment reminders, or information about the clinic. You have the right, in writing, to limit uses or disclosures and to revoke your authorization. Authorization cannot be revoked if information has already been released. Without your consent, Kavanagh Chiropractic will not be able to submit claims to your insurance carriers or other third party payors and may not accept you as a patient.

X_____I authorize this health care facility to release all information related to the care I receive to my HMO, insurance company, third party payor or their designee. I understand that this may be necessary for the payment of my bill, determining benefits or for utilization and quality review purposes. We may also use your information for reminder calls and mailings from our office.

Information about Possible Risk of Chiropractic Treatment

X_____You have the right, as a patient, to be informed about your condition and the recommended integrative and complementary procedure to be used so that you make an informed decision whether or not to undergo the procedure after knowing the risks and hazard involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or withhold your consent to the procedure. Doctors of chiropractic, Medical Doctors and Physical Therapists using manual therapy treatment for patients with headaches and cervical spine (neck) complaints are required to explain that there have been rare cases of injury to a vertebral artery as a result of treatment. Such an injury has been known to cause a stroke, sometimes with serious neurological damage. The rare chance of this happening is estimated to be approximately from 1 per 400,000 treatments to 1 per 10 million treatments. Appropriate tests will be performed to help identify if you may be susceptible to this type of injury; you will be notified if that is the case. If you have any questions about this, please do not hesitate to speak with your practitioner. As with any health procedure, complications may arise during treatment. These complications include soreness, muscle or ligament strain, dislocations, fractures, disk injuries or physiotherapy burns. These are extremely rare occurrences.

Assignment of Benefits

X_____ I assign all benefits payable to me for my care to Kavanagh Chiropractic. I understand that this health care facility will be paid directly by the insurance company or other payor. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is considered as valid as the original.

Guarantee of Payment

X_____ I guarantee payment of all charges incurred for treatment in accordance with the rates and terms of this health care facility. Your insurance policy is an agreement between you and your insurance company, not between the insurance company and this chiropractic office. All benefits quoted are a general outline and are not a guarantee of payment. As a courtesy to our patients, the clinic will submit all eligible charges to the insurance company for the patient. It is to be understood that all services rendered are 100% the patient's responsibility. Cash patients are required to pay at each visit. Co-pays must be paid at each visit.

Consent for Treatment

X_____ I authorize the performance of diagnostic tests, procedures and treatment deemed necessary by personnel involved in my care.

Cancellation

X_____A 24-hour notice must be given to reschedule or cancel a chiropractic appointment. If an appointment is missed, the patient must pay a $25 cancellation fee for the appointment. Insurance companies are not responsible to pay for missed appointments and will not be billed.

Nutritional Supplements/Orthopedic Supports

X_____All supplements/vitamins and orthopedic supports or supplies must be paid IN FULL at time of service. Supplements/vitamins are non-returnable.

Authorization to Treat a Minor (under the age of 18)

X_____I hereby request and authorize my doctor at this clinic to perform diagnostic tests and render chiropractic adjustment and other treatment to my minor son/daughter. As of this date, I have legal right to select and authorize health care services for the minor child named above. Under the terms and conditions of my divorce (if applicable), separation or other authorization, the consent of a spouse/former spouse or other parent is not required. If my authority to so select and authorize this care should be revoked or modified in anyway, I will immediately notify Kavanagh Chiropractic.

Name (Printed):_____ Date:_____

Signature of Patient or Responsible Party:_____ Relationship to Patient:_____

PATIENT HEALTH QUESTIONNAIRE

Kavanagh Chiropractic

Patient Name:_____ Date:_____

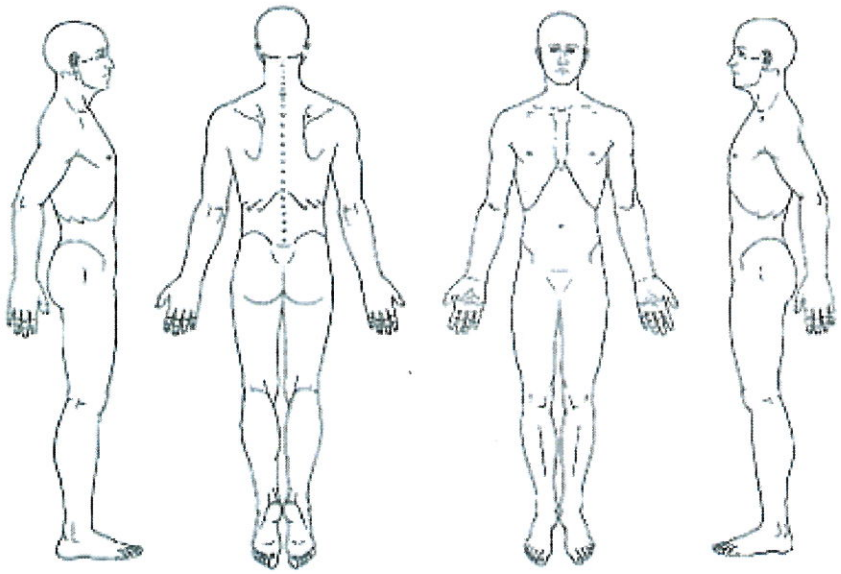
1. What is your child's primary complaint? _____

_____

2. When & how did your child's symptoms begin? _____

_____

3. Has your child experienced any recent trauma/injury? ① Yes ② No
4. Does your child appear to be in pain/discomfort? ① Yes ② No
5. Who has your child seen for their symptoms? ① No One ② Other Chiropractor ③ Medical Doctor ④ Physical Therapist ⑤ Other
   a. When and what treatment? _____
   b. Were imaging studies ordered? ① Xrays *date:*_____ ② MRI *date:*_____ ③ CT Scan *date:*_____ ④ Other *date:*_____
6. Has your child experienced this complaint before? ① Yes ② No
7. What activities make symptoms better? _____
8. What activities make symptoms worse? _____
9. Please indicate where your child is experiencing symptoms, and grade the level of severity on average.



PATIENT HEALTH QUESTIONNAIRE

Patient Name:_____ Date: _____

Average activity level: ①None ②Light ③Moderate ④Strenuous

Current height and weight: Height [ ][ ][ ] (Feet / Inches) Weight [ ][ ][ ] lbs.

For each of the conditions below, please mark the past column if you have experienced this condition in the past. If you are currently experiencing a condition listed below, please mark the present column.

Past	Present		Past	Present		Past	Present	
☐	☐	Headaches	☐	☐	Dizziness	☐	☐	Diabetes
☐	☐	Neck Pain	☐	☐	Visual Disturbances	☐	☐	Autoimmune Conditions
☐	☐	Upper Back Pain	☐	☐	Ear Infections	☐	☐	Congenital Conditions
☐	☐	Mid Back Pain	☐	☐	Vision/Hearing Impairments	☐	☐	Bed Wetting
☐	☐	Low Back Pain	☐	☐	Sinus Infections/Frequent Colds	☐	☐	Sleep Disturbances
☐	☐	Shoulder Pain	☐	☐	Asthma	☐	☐	Regression of Milestones
☐	☐	Elbow/Arm Pain	☐	☐	Allergies	☐	☐	ADD/ADHD
☐	☐	Wrist/Hand Pain	☐	☐	Eczema/Rashes	☐	☐	Autism/PDD
☐	☐	Hip/Upper Leg Pain	☐	☐	Digestive Issues	☐	☐	Loss of Bowel/Bladder Control
☐	☐	Knee/Lower Leg Pain	☐	☐	Frequent Diarrhea	☐	☐	Abnormal Weight Loss/Gain
☐	☐	Ankle/Foot Pain	☐	☐	Constipation	☐	☐	Abdominal Pain
☐	☐	Jaw Pain	☐	☐	Kidney/Bladder Infections	☐	☐	Cancer
☐	☐	Joint Swelling/Stiffness	☐	☐	Cardiovascular Complications	☐	☐	Tumor
☐	☐	Juvenile Arthritis	☐	☐	Stroke	☐	☐	Other_____
☐	☐	Fractures/Broken Bones	☐	☐	Epilepsy/Seizures	☐	☐	Other_____

Indicate if an immediate family member has had any of the following:

○ Rheumatoid Arthritis ○ Heart Problems ○ Diabetes ○ Cancer ○ Lupus ○_____

List all prescription and over-the-counter medications, and nutritional/herbal supplements you are taking:

_____ _____ _____

_____ _____ _____

List all the surgical procedures you have had and times you have been hospitalized:

_____ _____ _____

_____ _____ _____

Patient Signature _____ ***Date*** _____

Doctor's Additional Comments

_____

_____

_____

Doctors Signature _____ ***Date*** _____