# Eilrich Family Chiropractic & Wellness Ages 0-2 Intake Form

We would like to take this opportunity to welcome you to Eilrich Family Chiropractic & Wellness. Please help us better serve you and your child by taking time to fill in the information below to the best of your knowledge. At Eilrich Family Chiropractic & Wellness, we enjoy treating patients from newborn to long-lived and we look forward to working with you and your child.

# **Legal Information**

Patient Full Name:		Preferred Name:					
Home Address:							
City:	State:	Zip Code:	Best contact #	:			
Email Address:		Birth Date:	//	Age Today:	Gender: M F		
Mother's Name:		Pho	one #:		_		
Father's Name:		Pho	one #:		_		

### **Medical Information**

Pediatrician/Family MD:	
Date of Last Visit:	Reason for Last Visit:
Immunization History:	
Has your child taken antibiotics in the past: Yes, No If ye	es, how many times?
Past Chiropractor's Name:	

# How did you hear about the clinic? \_\_\_\_\_\_

### **Present Condition History**

This section is your chance to describe why you are bringing your child into our office, be honest and give as many details as you can to what is going on.

Describe the reason for this visit (include **when** and **how** this started):

What makes it worse?	or injury?	What		Auto □Other: ?	
	vith your child's normal da	•			
Has your child been seen	by any other providers fo	r this, whom?			
What treatment did h	e/she receive and when? _				
What tests have been	performed to check into the	he symptoms and wh	nen were they pe	erformed?	
$\square$ X rays <i>date</i> :	□ CT Scan <i>date</i> :	$\_\_$ $\Box$ MRI date: $\_$	🗆 Oth	ner date:	
	n the past? $\Box$ Yes $\Box$ No	_	_		
Health History					
In general, would you say	y your child's overall heal	th right now is:			
□ Excellent	□ Very Good	□ Good	□ Fair	$\square$ Poor	
List any mediations or su	pplements your child is cu	urrently taking:			
List all surgical procedur	es and times your child ha	s stayed in the hospi	tal:		

Has your child reached all of their developmental milestones such as (responding to sound, following objects with his/her eyes, holding up head, sitting alone, crawling, standing, walking, talking, etc.):  $\Box$  Yes  $\Box$  No If no please explain:

Has your child fallen from a high place during their first year of life (i.e., bed, changing table, down stairs, etc.)? Was this the case with your child? □ Yes □ No If yes, please explain: \_\_\_\_\_

Any major accident or injuries (including falls, fractures, auto, etc.):

#### .1. 1.1.1 - CC - . . . 1 . C ... тт 0

Has your child ev	ver suffered fro	om ?							
Headache		Muscle/0	Growing	🗆 Skin	Problems	□ (	Constipation/	/Diarrhea	
	Pa	ains							
□ Neck Problems	S 🗆	Broken I	Bones	Bloo	d Disorder		Reflux		
□ Back Problems	S 🗆	Asthma		🗆 Diab	etes		Bladder Infed	ction	
□ Shoulder/Arm	Problems	Seizures	/Convulsion	is $\Box$ Bed	Wetting	□ (	Colds/Flu		
Hip/ Leg Probl	ems 🗆	Colic			avioral Problem		Cancer/Tumo	or	
$\Box$ Scoliosis		Poor/Exc	cessive	$\Box$ Chro	onic Ear Aches		Sinus Troubl	e	
		ppetite							
□Walking Troub			e Troubles	🗆 Resp	oiratory Problem	ms □ /	Allergies:		
□ Orthopedic Pro		Stomach		1	5		Others:		
1									
<b>Birth History</b>									
How was the mo	ther's pregnand	ev with th	ne child?	Easy	Moderate	Diffic	ult		
Where there any	complications	with the	$\overline{\text{pregnancy}?}$	Yes	No				
If so, what we	re they?		r 8 sj						
If so, what we What was the mo	other's labor lik	ce with th	ne child?						
	ld delivered?	Caesa	rian Sectior	n Vagin	al Delivery	Forceps	Vacuur	n Devise	
How was the chi								n Devise	
How was the chi Where was the cl	hild delivered a	at? H	Iome	Hospital	Other			n Devise	
How was the chi Where was the cl Was the child in	hild delivered a overall good h	at? H ealth afte	Home r delivery?	HospitalYes	Other No				
How was the chi Where was the cl Was the child in If not, what wa	hild delivered a overall good h as going on wit	at? H ealth afte th the chi	Home r delivery? ld?	HospitalYes	Other No				
How was the chi Where was the cl Was the child in If not, what wa Was the child Br	hild delivered a overall good h as going on wit east Fed	at? H ealth afte th the chi or Form	Home r delivery? ld? ula Fed	HospitalYes?	OtherNo				
How was the chi Where was the cl Was the child in If not, what wa Was the child Br If Breast Fed	hild delivered a overall good h as going on wit east Fed how long were	at? H ealth afte th the chi _ or Form e, they br	Iome r delivery? ld? ula Fed east fed for	HospitalYes?	Other No				
How was the chi Where was the cl Was the child in If not, what wa Was the child Br If Breast Fed If formula fed	hild delivered a overall good h as going on wit east Fed how long were d what kind of	at? H ealth afte th the chi _ or Form e, they br formula	Iome r delivery? ld? ula Fed east fed for and how lon	HospitalYes? ? ? g?	Other No				
How was the chi Where was the cl Was the child in If not, what wa Was the child Br If Breast Fed	hild delivered a overall good h as going on wit east Fed how long were d what kind of	at? H ealth afte th the chi _ or Form e, they br formula	Iome r delivery? ld? ula Fed east fed for and how lon	HospitalYes? ? ? g?	Other No				
How was the chi Where was the cl Was the child in If not, what wa Was the child Br If Breast Fed If formula fee Has the child had	hild delivered a overall good h as going on wit east Fed how long were d what kind of l any difficultio	at? H ealth afte th the chi _ or Form e, they br formula a es with ea	Home r delivery? ld? ula Fed east fed for and how lon ating at any	HospitalYes ? ? g? time if so, v	Other No	?			
How was the chi Where was the cli Was the child in If not, what wa Was the child Br If Breast Fed If formula fee Has the child had	hild delivered a overall good h as going on wit east Fed how long were d what kind of any difficultion our child sleep	at? H ealth afte th the chi _ or Form e, they br formula a es with ea ?	Home	HospitalYes ? ? g? time if so, v	OtherNo	? any hours	per day?		
How was the chi Where was the cl Was the child in If not, what wa Was the child Br If Breast Fed If formula fee Has the child had	hild delivered a overall good h as going on wit east Fed how long were d what kind of any difficultion our child sleep	at? H ealth afte th the chi _ or Form e, they br formula a es with ea ?	Home r delivery? ld? ula Fed east fed for and how lon ating at any  or would the	HospitalYes ? ? ; g? time if so, v  ey rather be	OtherNo	? any hours	per day?		
How was the chi Where was the cl Was the child in If not, what wa Was the child Br If Breast Fed If formula fed Has the child had How well does y Does your child I	hild delivered a overall good h as going on wit east Fed how long were d what kind of any difficultie our child sleep like to play wit	at? H ealth afte th the chi _ or Form e, they br formula es with ea ? h others o	Home r delivery? ld? east fed for' and how lon ating at any or would the Fa	HospitalYes ? ? ?  time if so, v  ey rather be <b>mily Histor</b>	Other No what were they How m by themselves ¥	? Alo	per day? ne With	hours Others	ther or
How was the chi Where was the cli Was the child in If not, what was Was the child Br If Breast Fed If formula fed Has the child had How well does y Does your child I Please check any	hild delivered a overall good h as going on wit east Fed how long were d what kind of any difficultion our child sleep like to play wit	at? H ealth afte th the chi _ or Form e, they br formula es with ea ? h others o	Home r delivery? ld? east fed for' and how lon ating at any or would the Fa	HospitalYes ? ? ?  time if so, v  ey rather be <b>mily Histor</b>	Other No what were they How m by themselves ¥	? Alo	per day? ne With	hours Others	ther or
How was the chi Where was the cl Was the child in If not, what wa Was the child Br If Breast Fed If formula fed Has the child had How well does y Does your child I	hild delivered a overall good h as going on wit east Fed how long were d what kind of any difficultion our child sleep like to play wit of the following enced.	at? H ealth afte th the chi _ or Form e, they br formula a es with ea ? h others of ng condit	Home r delivery? ld? east fed for and how lon ating at any or would the <u>Fan</u> ions that an	HospitalYes Yes ? g? time if so, v ey rather be <b>mily Histor</b> immediate	Other No what were they How m by themselves <u>Y</u> family membe	? any hours ? Alo r (grandpa	per day? ne With rents, mothe	hours hours Others r, father, bro	
How was the chi Where was the cli Was the child in If not, what was Was the child Br If Breast Fed If formula fed Has the child had How well does y Does your child I Please check any	hild delivered a overall good h as going on wit east Fed how long were d what kind of any difficultion our child sleep like to play wit	at? H ealth afte th the chi _ or Form e, they br formula es with ea ? h others o	Home r delivery? ld? east fed for' and how lon ating at any or would the Fa	HospitalYes ? ? ?  time if so, v  ey rather be <b>mily Histor</b>	Other No what were they How m by themselves ¥	? Alo	per day? ne With	hours Others	ther or Other

	pressure/ Cholesterol	attack	Cancer	Diabetes	Problems	SHOKE	Atumus	Disease	Other
Mother									
Father									
Sister									
Brother									
Grandparents									

# Authorization for Care of Minor

I hereby request and authorize Eilrich Family Chiropractic &Wellness to perform diagnostic tests and render chiropractic adjustments and other treatment to the minor listed as the patient (upon approval of Parent or Guardian). As of the date, I have legal right to select and authorize health care services for the minor named above. If applicable under the terms and conditions of my divorce, separation, or other legal authorization, the consent of a spouse/ former spouse or other parent is not required. If my authority to select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

# Patient Acceptance (please read carefully)

- We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly mutual understanding between patient and provider.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform Eilrich Family Chiropractic & Wellness of any changes in my medical status.
- I authorize Eilrich Family Chiropractic & Wellness to release any information deemed appropriate concerning my physical condition to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred by me.
- I authorize the direct payment to you by any sum I now or hereafter owe you by my attorney out of the proceeds of any settlement of my case, and by any insurance company obligated to make payment to me or you based in whole or in part upon the charges made for your services. I authorize the use of this signature on all insurance submissions.
- I understand that whatever amounts not collected from insurance proceeds (whether it be all or part of what is due) I personally owe Eilrich Family Chiropractic & Wellness the remaining account balance.
- I understand that if I do not notify Eilrich Family Chiropractic & Wellness 24 business hours prior to my scheduled appointment and/or miss a scheduled appointment
  - I will be charged a \$15.00 cancellation fee for any Doctor Appointment
  - \*\*These fees will not be covered by my insurance and will be billed to me personally\*\*
- I understand and agree health and accident insurance policies are an agreement between an insurance carrier and me. I clearly understand and agree that all the services rendered in office are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate any care and treatment, any fees for professional services rendered by me will be immediately due and payable, I will be responsible for my costs of collection, attorney's fees or court costs required to collect my bill.
- I understand that if I arrive to my appointment more than 7 minutes late, I may have to wait to get seen by the Dr or reschedule for another day.
- Super Thursday (20% off all nutrition) is every 3<sup>rd</sup> Thursday of the month. There will no longer be exceptions to this rule. We allow people to get items at this discount if they are in for a scheduled appointment that week, however we will not allow anyone to use this discount outside of designated time frame. You may call and pay via Credit Card if you are unable to pick up on scheduled day.

Patient (or responsible party) Signature

Relationship to Patient

Date

## **Notice of Privacy Practices Acknowledgement and Consent**

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPPA) and specifically its privacy rule, I have certain rights to privacy regarding my Protected Health Information (PHI). I understand that my PHI will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers that may • be involved in my treatment directly or indirectly.
- Obtain payment and reimbursement from health coverage programs and others.
- Conduct normal healthcare business operations including routine aspects of operating a health-related practice or business.

I have received and read and understand the Notice of Privacy Practices containing a more complete description of the creation, uses and disclosure of my PHI. I understand that Eilrich Family Chiropractic & Wellness has the right to change its Privacy Practices from time to time and I may contact the Privacy Officer for Eilrich Family Chiropractic & Wellness at or through the addresses listed to obtain a current copy of the Notice of **Privacy Practices.** 

I also understand that I may request in writing that you restrict how my PHI is used and disclosed to carry out treatment, payment, or healthcare operations. However, I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions. I further understand that I may revoke this consent in writing at any time, except to the extent you have taken action relying on this consent.
Signature: \_\_\_\_\_\_

Legal Guardian Signature (if applicable): \_\_\_\_\_

Print Name: Date:

# **Informed Consent**

Any procedure intended to help, may also do harm. While chiropractic and therapeutic procedures (e.g., spinal adjustments, ultrasound, heat and cold application, electrotherapy and manual muscle therapy) are considered remarkably safe and effective, please understand that occasionally there may be adverse reactions.

Although the chances of experiencing any of these complications are extremely small, it is the practice of Eilrich Family Chiropractic & Wellness, to fully inform and educate all our patients. These complications include, but are not limited to:

Pain Swelling Bruising Disc Injury Sensory Changes Bleeding Burns Weakness Bone Fracture Soft Tissue Injury Nausea Stroke Dizziness Spinal Cord Damage Worsening of Condition Discoloration I understand there is no guarantee or warranty for a specific cure or result. I understand that I can request further explanation regarding any and all possible attendant to my care.

Signature: \_\_\_\_\_

Legal Guardian Signature (if applicable):

Print Name: \_\_\_\_\_\_ Date: