Eilrich Family Chiropractic & Wellness 3-12 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: _____ Phone #: _____-_____-_____
Father's Name: _____ Phone #: _____-_____-_____

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 yes, 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):_____
_____
Is this due to an accident or injury? □ Yes □ No Date: _____ Type of accident: □ Auto □Other: _____
What makes it worse? _____ What makes it better? _____
How has this interfered with your child's normal daily activities? _____
Has your child been seen by any other providers for this, whom? _____
What treatment did he/she receive and when? _____
What tests have been performed to check into the symptoms and when were they performed?
□ X rays *date*: _____ □ CT Scan *date*: _____ □ MRI *date*: _____ □ Other *date*: _____
Has your child had this in the past? □ Yes □ No

Health History

In general, would you say your child's overall health right now is:
□ Excellent □ Very Good □ Good □ Fair □ Poor
List any mediations or supplements your child is currently taking: _____
_____
List all surgical procedures and times your child has stayed in the hospital: _____
_____

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.): □ Yes □ No?

If no please explain: _____
_____
Has your c 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.): _____
_____
Has your child ever sustained any injury playing organized sports? □ Yes □ No If yes, please explain:
_____

Has your child ever suffered from?

□ Headache	□ Muscle/Growing Pains	□ Skin Problems	□ Chronic Constipation/Diarrhea
□ Neck Problems	□ Broken Bones	□ Blood Disorder	□ Reflux
□ Back Problems	□ Asthma	□ Diabetes	□ Bladder Infection
□ Shoulder/Arm Problems	□ Seizures/Convulsions	□ Bed Wetting	□ Colds/Flu
□ Hip/ Leg Problems	□ Dizziness or Fainting	□ Behavioral Problems	□ Cancer/Tumor
□ Scoliosis	□ Poor/Excessive Appetite	□ ADD/ADHD	□ Sinus Trouble
□ Walking Trouble	□ Digestive Troubles	□ Chronic Ear Aches	□ Allergies: _____
□ Orthopedic Problem	□ Stomach Aches		□ Others:

Birth History

How was your pregnancy and delivery with this child? _____
_____
_____
Was your child Breast Fed_____ or Formula Fed____? For how long? _____
How well does your child sleep? _____ How many hours per day? _____ hours

Family History

Please check any of the following conditions that an immediate family member (grandparents, mother, father, brother or sister) has experienced.

	Blood pressure/ Cholesterol	Heart attack	Cancer	Diabetes	Lung Problems	Stroke	Arthritis	Thyroid 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 and/or**
    - **Half the cost of scheduled massage.**

      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 3rd 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
Nausea Stroke Dizziness Weakness Bone Fracture Soft Tissue Injury
Worsening of Condition Spinal Cord Damage 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: _____