Family First Chiropractic

Youth Intake Form
(11 – 15 years)

Personal Information

First Name ___________________ Middle Initial ____ Last Name ______________________________

Street ____

City ______________________ State _____________ Zip Code _______________ Email _____________________________

Home Phone (_____) ________-____________ Cell Phone (_____) ________-__________

Date of Birth _______/_______/________ Age ___________________

Sex ☐ Male ☐ Female Social Security Number ____-____-______

Emergency Contact

Contact Name ___________________________________ Relationship to Patient ____________________________________

Contact Home Phone (_____) _______-_________ Cell Phone (_____) _____-____________

Payment/Insurance Information

Personal Health Insurance Carrier ________________________ Ins. Card ID # ____________________________________

Policy Holder's Name ____________________________ Relationship _______________ Group # ____________________

Policy Holder's Date of Birth ______ / _____ / ______ Policy Holder's SSN: _____________________________________

Policy Holder's Employer ____

Patient History

Name of Pediatrician: ____

Date of last visit ___________________________ Reason: ____

Do you exercise? ☐ No ☐Yes Describe ____

Do you sleep on your: ☐ Back ☐ Stomach ☐ Left Side ☐ Right Side ☐ Both Sides

What sports/activities do you participate in? ____

____

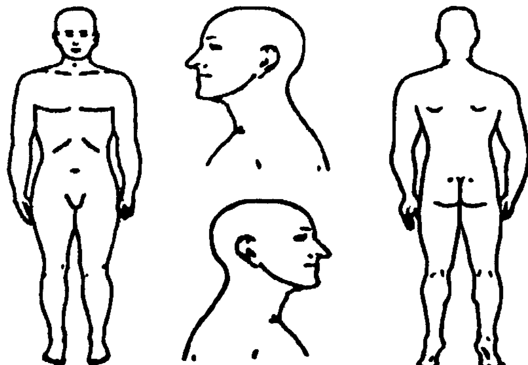
List any **Allergies**	**Medications**	**Vitamins/Herbs/Minerals**

Injuries/Surgeries	**Description**	**Date**
Falls		
Head Injuries		
Broken Bones		
Dislocation		
Surgeries		
Car Accident(s)		

Please indicate if you have had any of the following

☐ Ankle Pain	☐ Eye/Vision Problems	☐ Jaw Pain	☐ Shoulder Pain
☐ Arm/Elbow Pain	☐ Fainting	☐ Knee Pain	☐ Significant Weight Change
☐ Arthritis	☐ Fatigue	☐ Leg Pain	☐ Spinal Cord Injury
☐ Asthma	☐ Foot Pain	☐ Low Back Pain	☐ Sprain/Strain
☐ Back Pain	☐ Genetic Spinal Condition	☐ Menstrual Problems	☐ Stomach Problems
☐ Cancer	☐ Hand Pain	☐ Mid-Back Pain	☐ Tumor. Where?
☐ Chest Pain	☐ Headaches/Migraines	☐ Minor Heart Problem	☐ Ulcer(s)
☐ Depression	☐ Hearing Problems	☐ Multiple Sclerosis	☐ Wrist Pain
☐ Diabetes	☐ High Blood Pressure	☐ Neck Pain	☐ Other
☐ Dizziness	☐ High Cholesterol	☐ Neurological Disorder	
☐ Epilepsy	☐ Hip Pain	☐ Parkinson's	

PLEASE MARK YOUR AREAS OF PAIN ON THE DIAGRAM BELOW



Main reason for consulting the office:
- ☐ Become pain free
- ☐ Explanation of my condition
- ☐ Learn how to care for my condition
- ☐ Reduce symptoms
- ☐ Resume normal activity level

Have you ever had chiropractic care? ☐ No ☐ Yes
When? ____________ Why? __________________
Where? ______________________________________
Were X-rays taken? ☐ No ☐ Yes
When was your last adjustment? _______________

Reason for visit: ____ Date problem began? ______________________

How did this problem begin? ____

Have you had this condition in the past? ☐ YES ☐ NO

Name of doctor(s) who have treated you for this condition ____

How is your condition changing? ☐ GETTING BETTER ☐ GETTING WORSE ☐ NOT CHANGING

Rate your pain on a scale of 1 to 10.(1 = no pain and 10 = excruciating pain) ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

How intense is your pain? ☐ Minimum ☐ Mild ☐ Moderate ☐ Severe ☐ Unbearable

Type of pain: ☐ Burning ☐ Dull Ache ☐ Numb ☐ Radiating Pain ☐ Sharp ☐ Shooting ☐Stabbing Pain ☐ Tightness ☐ Tingling ☐ Throbbing ☐ Other: ___________________

What makes your pain better? ☐ Acupuncture ☐ Chiropractic ☐ Heat ☐ Ice ☐ Massage ☐ Nothing Works ☐ Pain Medicines ☐Physical Therapy ☐ Sleep/Rest ☐ Stretching

How often do you experience your symptoms? ☐ Constantly ☐ Frequently ☐ Occasionally ☐ Intermittently

Does pain interfere with your: ☐ Work ☐ Sleep ☐ Recreation ☐ Daily Routine

Movements that are painful: ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

Do you have other complaints? ______________________________________ Date problem began? ________________

How did this problem begin? ____

Have you had this condition in the past? ☐ YES ☐ NO

Name of doctor(s) who have treated you for this condition ____

How is your condition changing? ☐ GETTING BETTER ☐ GETTING WORSE ☐ NOT CHANGING

Rate your pain on a scale of 1 to 10.(1 = no pain and 10 = excruciating pain) ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

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Neurological and Vascular History

Question		
Do You Suffer From Neck Pain With Pain In Your Shoulder, Arms, Or Hands?	**Yes**	**No**
Do You Have Weakness, Numbness, Or Burning In Your Shoulder, Arms, Or Hands?	**Yes**	**No**
Do Your Hands Or Arms Fall Asleep Regularly?	**Yes**	**No**
Do You Have Reduced Feeling (Sensation) Or Swelling In Your Hands Or Arms?	**Yes**	**No**
Do You Suffer From A Loss Of Hand Grip Strength?	**Yes**	**No**
Do You Suffer From Back Pain With Pain In Your Buttocks, Legs, Or Feet?	**Yes**	**No**
Do You Have Weakness, Numbness, Or Burning In Your Buttock, Legs, Or Feet?	**Yes**	**No**
Do Your Legs Or Feet Fall Asleep Regularly?	**Yes**	**No**
Do You Have Reduced Feeling (Sensation) Or Swelling In Your Legs Or Feet?	**Yes**	**No**
Do You Suffer From Cold Hands Or Feet?	**Yes**	**No**
Do You Suffer From Headaches, Dizziness, Or Memory Loss?	**Yes**	**No**
Do You Have Difficulty Maintaining Your Balance?	**Yes**	**No**
Do You Suffer From Vertigo Or Blurred Vision?	**Yes**	**No**
Do You Suffer From Reduced Hearing Capacity?	**Yes**	**No**
Do You Suffer From Ringing In Your Ears?	**Yes**	**No**
Do You Have Bladder Or Bowel Control Problems On A Regular Basis?	**Yes**	**No**

Consent to Treat a Minor

As the Legal Guardian of the Above Named Patient, I give my written consent for examination and/or treatment of the above stated patient to Family First Chiropractic. I accept financial responsibility for the Above Named Patient.

Consent to Treat a Minor: (Minor's Printed Name) ____

Guardian's Signature Authorizing Care: ____

Relationship: ______________________________________ Date__________________________________

Family First Chiropractic

Acknowledgement of Receipt of Notice of Privacy Practices

This form will be retained in your medical record.

NOTICE TO PATIENT

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice of Privacy.

The Standards for Privacy of Individually Identifiable Health Information ("Privacy Rule") establishes, for the first time, as set of a national standards for the protection of certain health information. The U.S. Department of Health and Human Services issued the Privacy Rule to implement the requirement of the **Health Insurance Portability and Accountability Act** of 1996 ("HIPAA"). A major goal of the Privacy Rule is to assure that individuals' health information is properly protected while allowing the flow of health information needed to provide and promote high quality health care and to protect the public's health and well being.

This document is to certify that the below named patient authorizes the request of any records pertinent to the health care of same individual from but not inclusive of any insurance carrier, adjustor, attorney or other health care provider.

This document also authorizes this facility to release records, upon receipt of the below named patient's signature, or on an emergency basis, to, but not inclusive of any insurance carrier, attorney, health care provider, hospital or immediate family member.

Financial Responsibility and Agreement

This document certifies that I agree to pay directly to Family First Chiropractic such sums of monies as may be due and owing them, (a) for medical services rendered to me and/or (b) for any other services, supplies, or reports and/or (c) legal medical (i.e. impairment rating reports, attorney-physician conferences, and depositions) as may be necessary to adequately protect and pay for my treatment. I fully understand that I am directly and fully responsible to the above health care provider for all medical bills submitted by them for services rendered to me and that this agreement is made solely for additional protection and in consideration of the services provided. I further understand that such payment is not contingent on any insurance company's determination, with the exception of a recognized workers compensation case, as to the appropriateness of services rendered and/or fees charged. Alternate third party payment, if accepted, is done as a courtesy provided by Family First Chiropractic.

This also certifies that the above named guarantor agrees to pay in full for all professional services rendered at the time they are performed, unless other arrangements are made in advance of the set appointment. The below named guarantor understands a $25.00 returned check fee will be charged along with any appropriate collection or attorney's fee which may accrue upon collection of any outstanding balance. The below named guarantor understands that if 24 hours' notice is not provided a $15.00 fee will be charged for a missed chiropractic appointment and $25.00 fee will be charged for a missed massage therapy appointment, except in an emergency situation.

A photocopy of this assignment shall be considered as effective and valid as the original. This document is considered a living document and does not expire.

Patient Name:________________________________ Date of Birth:__________

Financial Agreement

I acknowledge that I have received and /or have been given the opportunity to review Family First Chiropractic's "Financial Responsibility and Records Request" Form.

HIPAA Privacy Practices

I acknowledge that I have received and /or have been given the opportunity to review Family First Chiropractic's "Notice of Privacy Practices" Form for protected health information.

_______________________________________ _______________________________________

Patient's Signature or Legal Representative *Printed Name of Patient or Legal Representative*

_______________________________________ _______________________________________

Today's Date *If Legal Representative, Indicate Relationship*

Electronic Health Records Intake Form

This form complies with CMS EHR incentive program requirements

First Name: ____________________ **Last Name:** ____________________ **DOB:** ____________________

Email Address: ____@_________________________________

Preferred method of communication for patient EHR reminders (Circle one): Email / Phone / Mail

Preferred Language: ____

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) Native Hawaiian or Pacific Islander / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

Family Medical History ***(Record one diagnosis in your family history and the affected relative)***				
Diagnosis (Write in below)	Father	Mother	Sibling (circle): (brother/sister)	Offspring (circle): (son/daughter)
Example: Heart Disease				

Are you currently taking any medications? *(Include regularly used over the counter medications)*	
Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?			
Medication Name	Reaction	Onset Date	Additional Comments

□ **I choose to decline receipt of my clinical summary after every visit** *(These summaries are often blank as a result of the nature and frequency of chiropractic care.)*

Patient/Guardian Signature: ____ Date: ________________