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Child's Name: _____ Birth Date: ____/____/_____

Address: _____ City/Town: _____ State: _____ Zip: _____

Age: _____ Sex: _____ Number of Siblings: _____ Referred by: _____

Birth Weight: _____ Birth Length: _____ Current Weight: _____ Current Length: _____

Mother's Name: _____ DOB: ____/____/_____

Work Phone: _____ Cell Phone: _____

Father's Name: _____ DOB: ____ / ____ / _____

Work Phone: _____ Cell Phone: _____

Third Trimester Presentation: Vertex_____ Breech_____ Transverse_____ Face/Brow_____

Type of Birth: Normal Vaginal_____ Forceps_____ Cesarean_____ Suction Cap or Vacuum_____

Location: Home_____ Birthing Center_____ Hospital_____

Problems during pregnancy: _____

Problems during Labor/Delivery: _____

Apgar Scores: _____ _____ Was there presence at birth of: Jaundice (Yellow)?_____ Cyanosis (Blue)?_____

Congenital Anomalies/Defects?_____ If yes, please explain?_____

Infant Feeding: Breast_____ Bottle_____ If Bottle, which formula?_____

Number of Hours sleeping per night: _____ Quality of Sleep: Good_____ Fair_____ Poor_____

Obstetrician/Midwife: _____

Pediatrician/Family MD: _____

Date of Last Visit: ___/____/_____ Purpose: _____

Immunization History: _____

Number of Doses of Antibiotics your child has taken:

During the past six months____ During his/her lifetime____

Previous Chiropractor: _____

Date of Last Visit: ___/____/_____ Purpose: _____

Has your child ever been treated on an emergency basis? _____

If yes, please explain:_____

Purpose of this appointment: _____

Insurance/ Billing Information: _____ Policy #: _____

---

## AUTHORIZATION FOR CARE OF MINOR

I hereby authorize this office and its Doctors to administer care as they so deem necessary to my son/daughter/ward (upon approval of parent or guardian).

SIGNED: _____ DATE: _____

I realize that I am responsible for all fees charged by this office and I agree to pay for all services provided. X-rays remain the property of this office.

SIGNED: _____ DATE: _____

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Delivery/Birth History: _____
_____
_____
_____

At what age did the child:

Respond to Sound_____ Follow an Object with his/her Eyes_____ Hold Head Up_____
Sit Alone_____ Crawl_____ Stand_____ Walk Alone_____

At what age, if ever, did this child suffer from the following childhood diseases?

Chickenpox_____ Mumps_____ Measles_____ Rubella_____
Rubeola_____ Whooping Cough_____ Other_____

Has the child ever suffered from:

| | | | |
|---|---|---|---|
| ☐ Headaches | ☐ Orthopedic Problems | ☐ Digestive Problems | ☐ Behavioral Problems |
| ☐ Dizziness | ☐ Neck Problems | ☐ Poor Appetite | ☐ ADD/ADHD |
| ☐ Fainting | ☐ Arm Problems | ☐ Stomach Aches | ☐ Ruptures/Hernia |
| ☐ Seizures/Convulsions | ☐ Leg Problems | ☐ Reflux | ☐ Muscles Pain |
| ☐ Heart Trouble | ☐ Joint Problems | ☐ Constipation | ☐ Growing Pains |
| ☐ Chronic Earaches | ☐ Backaches | ☐ Diarrhea | ☐ Allergies to_____ |
| ☐ Sinus Trouble | ☐ Poor Posture | ☐ Diabetes | ☐ Allergies to_____ |
| ☐ Asthma | ☐ Scoliosis | ☐ Hypertension | ☐ Allergies to_____ |
| ☐ Colds/Flu | ☐ Walking Trouble | ☐ Anemia | ☐ Other_____ |
| ☐ Colic | ☐ Broken Bones | ☐ Bed Wetting | ☐ Other_____ |

Has this child ever suffered the following spinal traumas?

| | | |
|---|---|---|
| ☐ Fall in Baby Walker | ☐ Fall from Bed or Couch | ☐ Fall off Skateboard or Skates |
| ☐ Fall from Crib | ☐ Fall off Swing | ☐ Fall off Bicycle |
| ☐ Fall from Highchair | ☐ Fall off Slide | ☐ Fall down stairs |
| ☐ Fall from changing table | ☐ Fall off monkey bars | ☐ Other_____ |

Has this child ever sustained injuries in an auto accident? _____ If yes, please explain:_____
_____

Present History: _____
_____
_____
_____

Surgery: _____

Medications: _____

Accidents: _____

Family History: _____

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# Patient Acknowledgement and Receipt of Notice of Privacy Practices Pursuant to HIPAA and Consent for Use of Health Information

Name_____ Date_____
Print Patient's Name

The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant To HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request.

The undersign does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State law and Federal Law.

Dated this _____ day of _____, 20___

By_____
Patient's Signature

If patient is a minor or under a guardianship order as defined by State law:

By_____
Signature of Parent/Guardian (circle one)

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# Consent to Treat a Minor

Patient's Name: _____

The undersigned hereby requests and authorizes Active Life Family Chiropractic to perform diagnostic tests and render chiropractic adjustments and other treatment to (Print Patient's Name) _____ who is a minor child.

This authorization extends to all other clinics, doctors and office staff members and is intended to include radiographic examination at the doctor's discretion.

As of the date below, the undersigned states and avows that he/she has the legal right to select and authorize health care services for the minor child 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 so select and authorize this care should be revoked or modified in any way, the undersigned does hereby agree to notify the Doctor/Clinic as soon as is possible.

Signature: _____ Date: _____

Print Name: _____ Phone: _____

Relationship to Patient: _____

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# Electronic Health Records Intake Form

*This form complies with CMS EHR program requirements*

**First Name**:_____ **Last Name**:_____

**Email address:** _____@_____

**Preferred method of communication for patient reminders**:
(Circle one): Email / Phone / Text (Cell Carrier: _____)

**DOB:** __/__/____ **Gender (Circle one):** Male / Female **Preferred Language:** _____

**Smoking Status (Circle one):**Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked
**Smoking Start Date (Optional):** _____

| **Family Medical History *(Record one diagnosis in your family history and the affected relative)*** | | | | |
|---|---|---|---|---|
| **Diagnosis (Write in below)** | Father | Mother | Sibling: (_____) | Offspring: (_____) |
| *Example: Heart Disease* | | *X* | | |
| | | | | |

**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

| **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 would like to receive my clinical summary after every visit** *(These summaries are often blank as a result of the nature and frequency of chiropractic care.)*

**Patient Signature:** _____**Date:** _____

***For office use only***

Height: _____ Weight:_____ Blood Pressure:_____ /_____