Hamilton Chiropractic

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San Mateo, CA 94401

650-394-6045
www.hamiltonchiros.com

Pediatric Intake Form (5-12)

Child's Health Information

Child's Name:____ Date:______________________

Parent's Name:____

Address: ____

Email: ____ Phone: ______________________________

Date of Birth: ________/________/________ Height: ____________ Weight: _____________

How did you hear about us? ____

Referred by: ____

Has your child received chiropractic care? Yes No

If yes, previous DC's name and last visit date:____

Name of Primary Care Physician: ____

Condition Information

Child's complaints or concerns: ____

____

____

____

Please describe your child's current condition and any symptoms they are suffering from:

____

____

____

When did this begin? ____

How did the condition start? ____

What aggravates it? ____

What relieves it?____

Does it radiate? Y N If so, where does it travel? __________________________________

____

Has your child had similar conditions in the past? Y N

How frequently does your child experience the symptoms? (please circle)

Constantly 76-100% Frequently 51-75% Occasionally 26-50% Rarely 0-25%

Is the condition changing? (please circle)

Getting better Getting Worse Unchanged

Is your child's sleep interrupted? Y N Eating? Y N Daily Routine? Y N

Other professionals seen for this condition?____

Results of that treatment:____

Has your child experienced or is experiencing any of the following? (please circle)

Asthma	Seizures	Neck Pain	Respiratory Tract
Allergies	Slow Weight Gain	Infections	Food Sensitivities
Sinus Problems	Ear Infections	Tonsillitis	Sensory Processing Issues
Torticollis/Head Tilt	Weight Challenges	Tip Toe Walking	Slow or Absent Reflexes
Strep Throat	Back Pain	Eczema	Frequent Crying Spells
Tremors/Shaking	Growing Pains	ADD/ADHD, Autism	Frequent Colds/Croup
Bed Wetting	Rashes	Constipation	Swollen or Painful Joints
Scoliosis	Flatulence	Night Terrors	Headaches/Migraines
Digestive Problems	Colic	Sleep Problems	Asymmetrical crawling/gait

Any additional or explanations ____

____

History of Birth

What was the child's gestational age at birth? __________ Weeks

Was the child's birth at home or in a hospital? (please circle one)

Who was on your birth team? (please circle) OB/GYN NP RN Midwife Doula

What was the duration of the labor and birth?____

Were there any complications? Y N If so, please explain ____________________________

____

Was there any assistance used during birth? (please circle one)

Forceps Vacuum C-Section

Was labor spontaneous or induced? (please circle one)

Physical Stressors

Has the child had any falls from any high places, like the couch, beds, etc? Y N

If yes, please explain ____

____

Have they had any traumas resulting in bruises, cuts, stitches or fractures? Y N

If yes, please explain ____

____

Has the child had any hospitalizations or surgeries? Y N

If yes, please explain ____

____

Do you feel that your child's social and emotional development is normal for their age? Y N
If no, please explain ____

____

Does your child use any of the following? (please circle)

TV	Never	Rarely	Daily	Several	__________	hrs/day
Computer	Never	Rarely	Daily	Several	__________	hrs/day
Video games	Never	Rarely	Daily	Several	__________	hrs/day
Tablet	Never	Rarely	Daily	Several	__________	hrs/day

Chemical Stressors

Top 3 Best Foods They Eat:

____

____

____

Top 3 Worst Foods They Eat:

____

____

____

How many glasses of water a day _________ 0_________1-3________4-6________7-9________10+
How many glasses of juice, milk, soda a day _______0_______1-3_______4-6_______7-9________10+
Any exposure to second hand smoke? Y N If yes, how often? ___________________________
Has your child taken antibiotics? Y N How many times? ________________________________
Does your child take any probiotics or supplements? Y N
If yes, please list: ____

Family Health History

Please note any health problems (ie. cancer, hereditary conditions, diabetes, heart disease, etc.) that are present in:
Mother's family ____
Father's family____
Siblings ____

Consent

Authorization for care for a minor (16years)
Parent (s) Name: ____
I hereby authorize and consent to the chiropractic evaluation and care of my child by Hamilton Chiropractic.
Parent/Guardian Signature: ____Date: ____________________
Witness Signature: ____

In addition, by signing below, I give permission for the above named minor patient to be managed by the doctor even when I am not present to observe such care.

Printed name of person legally authorized to sign:
Name: ____

Signature: ____

Relationship to Patient: ____

Financial Policy

Restoring your health is our foremost objective. Our treatment will always be rendered solely on the base of need. Please advise us if you are unable to fulfill this policy so that we may discuss and consider alternative payment options. We require payment at the time of service unless special arrangements have been previously made. Our fees comply with the usual and customary rates for this region. We accept checks, cash, or credit card payments.

MEDICARE: Medicare pays for only a portion of chiropractic services and limits the number of reimbursements treatments. Reimbursable care is limited to spinal manipulation and does not include other therapies, services, and goods that may be necessary during care. Please be advised of the following Medicare restrictions and regulations.

- Medicare will pay for a maximum number of treatments per calendar year, based on your diagnosis. When the maximum number of treatments has been rendered, payment is expected at the time of service.
- Medicare will NOT pay for an initial examination. This fee is the patient's responsibility and will not apply to the patient's deductible.

PERSONAL INJURY, WORKER'S COMPENSATION AND/OR LITIGATION: If your complaint is the result of an occupational or automobile accident, or if litigation is pending, please notify us. If an attorney is involved, patients are required to sign a Physician's Lien that will be forwarded to the attorney for signature. If we do not receive the signed lien from the attorney within 14 days, all services must be paid for by the patient at the time rendered. It is our policy to bill the insurance company directly and will provide the attorney with a statement.

Instances will arise when we exhaust all reasonable efforts to secure payments through your insurance company, but the insurance company refuses payment. We will do our best to assist you in securing payments, but all balances are ultimately your responsibility.

MISSED APPOINTMENTS: There is a missed appointment fee in the amount of the appointment ($65.00 or $75.00) charged for missed appointments without a **24-hour** notice. This charge is the patient's responsibility and cannot be billed by the insurance company. Missed appointments fees must be paid before scheduling subsequent appointments. We may request a deposit for future appointments. If more than three appointments are missed without notification, we will recommend you seek treatment at another facility, or schedule care when you are able to commit to the recommended treatment program.

In fairness to our patients who do pay for service, after reasonable efforts on our part to obtain payment, we will solicit the service of a collection agency if necessary.

I have read this financial policy and understand that I am financially responsible for all unpaid balances for my care.

Patient Signature:____ Date: __________________

Our Privacy Pledge

We are very concerned with protecting your privacy. While the law requires us to give you a copy of this disclosure, please understand that we have, and always will, respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health care information.

- We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your health information within our practice for quality control or other operational purposes.

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before you sign this consent form (164.520). We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment or by mail. Please feel free to call us at any time for a copy of our privacy notices.

Your right to limited uses or disclosures
You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us.

Your right to revoke your authorization
You may revoke your consent to us at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you are required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

I have read your consent policy and agree to it terms. I am also acknowledging that I have received a copy of this notice.

______________________________ ______________________________
Patient Name Authorized Provider Representative

______________________________ ______________________________
Signature Date

____
Date

CHIROPRACTIC TREATMENT INFORMED CONSENT

The nature of the chiropractic manipulation: The primary treatment used by doctors of chiropractic is manual manipulation, also known as adjustment. I will use that and any other chiropractic procedures, including examination tests, diagnostic x- ray(s) and physical therapy techniques to treat the patient now and in the future. I will apply my hands to the area of your body to be treated in such a way as to move your joints. This may cause an audible “pop” or “click” similar to when you “crack” your knuckles. You may feel or sense movement.

The materials risks inherent in chiropractic adjustment: There are potential complications that may arise with any health care procedure. During manipulation, those complications include (but are not limited to); fractures, disc injuries, dislocations, muscle strain, Horner's syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and/or separations. Some patients will feel stiffness and soreness following the first few days of treatment. Some techniques used to manipulate the cervical spine (neck region) have been implicated in injuries to arteries in the neck leading to, or contributing to, serious complications that include stroke. I have also indicated that with any procedure there is the possibility of an unexpected complication, though no guarantees or promises can be made concerning the results of any procedure or treatment.

The probability of those risks occurring: Fractures are rare occurrences and generally result from some underlying weakness of the bone. We screen for these risk factors during the history, examination and on x-rays (if x-rays are indicated). Manipulation induced stroke has been a subject of disagreement within and outside the profession. One prominent authority (Haldeman,DC,MD) states that there is, at most, a one-in-a-million chance of such an outcome. Since that risk should be avoided, we employ tests in our examination that are designed to identify whether you may be susceptible to such an injury. The other complications are also generally described as “rare”.

Treatment options other than chiropractic:

- Do nothing
- Self administered including over the counter analgesic and rest
- Medical care with prescription drugs such as anti-inflammatory, muscle relaxation and pain killers
- Surgery, Hospitalization, traction, rehabilitation

Risks inherent in other treatment options:

• The risk involved in doing nothing and remaining untreated. The formation of adhesions and loss of mobility sets up a pain pattern that may result in a chronic condition. Over time this may prolong treatment, make it more difficult and less effective.

• The risk in self administered treatment may result in overuse of over-the-counter medications which can produce undesirable side effects. If complete rest is impractical, premature return to work and other activities may aggravate the condition and extend the recovery time. The probability of such complications depends on the patient's general health, severity of discomfort, pain tolerance and self-discipline.

• The risk involved with medical care and prescription drugs. Undesirable side effects and dependence on drugs. The risk also depends on the patient's general health, severity of discomfort, pain tolerance, self discipline and medical supervision. Medications generally entail significant risks, some with higher probabilities.

• The risk involved in surgery. Adverse reaction to anesthesia, iatrogenic (doctor caused) mishap, risk of hospitalization (exposure to communicable disease, iatrogenic mishap and expense), and an extended convalescent period. The probability of those risks occurring varies according to many factors.

DO NOT SIGN UNTIL YOU HAVE READ AND FULLY UNDERSTAND THE CHIROPRACTIC TREATMENT INFORMED CONSENT

Please check the appropriate block and sign below;

I have read [ ] or have had read to me [ ] the above explanation of the chiropractic adjustment and related treatment. I have discussed with Dr. Ryan or Dr. Elise Hamilton and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing chiropractic treatment and understand that there are other treatment options. By signing below I state I have myself decided that it is in my best interest to undergo the treatment recommended. Having been informed of the potential risks, I hereby give my consent to the aforementioned treatment.

Print Name:____ Date:__________________________

Signature:____

Signature of Parent/Guardian:____