VITAL PERFORMANCE CHIROPRACTIC

Pediatric Intake Form

Child's Name: ________________________ Birth Date: _____/_____/_________ Age: _________

Female / Male Height: ________ Weight: ________

Guardian's Name: ________________________ Birth Date: _____/_____/_________ Cell____________________

Home Address: ________________________ City: ________________________ State: __________

Zip: ______________ Email: ____

How did you hear about us? ____

Has your child ever been under Chiropractic Care? ◯ Yes ◯ No

What signals has your child's body been communicating? (C=Current, P=Previous)

C	P		C	P		C	P	
◯	◯	Asthma	◯	◯	Frequent Diarrhea	◯	◯	Failure to Thrive
◯	◯	Respiratory Infections	◯	◯	Constipation	◯	◯	Slow or Absent Reflexes
◯	◯	Sinus Issues	◯	◯	Flatulence	◯	◯	Asymmetrical Crawling/Gait
◯	◯	Ear Infections	◯	◯	Headaches / Migraines	◯	◯	Weight Challenges
◯	◯	Tonsillitis	◯	◯	Neck Pain	◯	◯	Bed Wetting
◯	◯	Strep Throat	◯	◯	Back Pain	◯	◯	Sleep Problems
◯	◯	Frequent Sickness	◯	◯	Growing Pains	◯	◯	Concentration Issues
◯	◯	Recurrent Fevers	◯	◯	Torticollis/Head Tilt	◯	◯	Tip toe walking
◯	◯	Eczema	◯	◯	Trouble feeding on one side	◯	◯	Sensory Processing Issues
◯	◯	Rashes	◯	◯	Scoliosis	◯	◯	Seizures
◯	◯	Allergies	◯	◯	Red, Swollen, Painful Joints	◯	◯	Tremors / Ticks
◯	◯	Food Sensitivities	◯	◯	Colic	◯	◯	ADD / ADHD
◯	◯	Digestive Issues	◯	◯	Frequent Crying	◯	◯	Autism

Any specific concerns that bring you in?

◯ No, I would like my child's nervous system assessed to achieve optimal health and functioning.

◯ Yes, ____

Does your child appear to be in pain or discomfort? ◯ Yes ◯ No When did it start? ____________________

Is it getting: ◯ better ◯ the same ◯ worse

Did it occur: ◯ suddenly ◯ gradually

Have you seen other health professionals regarding this concern? ◯ Yes ◯ No

If yes, whom? ____

What treatment did they use? ____

Has your child taken any medication for this complaint? ◯ Yes, ______________________________ ◯ No

Has your child ever experienced this complaint before? ◯ Yes, ______________________________ ◯ No

Has your child had x-rays in relation to the current complaint? ◯ Yes ◯ No

Why have you decided to have your child evaluated by a chiropractor?

- ◯ He/She is continuing care from another chiropractor.
- ◯ I recently had my spine checked and understand the value in getting my child checked.
- ◯ I have concerns about his/her health and I'm looking for answers.
- ◯ He/She has a specific condition and I've learned that chiropractic may be able to help.
- ◯ I want to improve my child's immune function.

Emergency Contact

Name: ______________________________ Relationship to Child: ______________________________

Phone Number: ______________________________

Family Doctor

Name: ______________________________ Professional Designation: ______________________________

Clinic Name: ______________________________ Date of last visit: ______________________________

May we communicate with your family doctor regarding your child's care if necessary? ◯ Yes ◯ No

Other Healthcare Professionals

(Medical Specialist, Naturopathic Doctor, Homeopath, Physiotherapist, OT, Massage Therapist, etc.)

Name: ______________________________ Professional Designation: ______________________________

Clinic Name: ______________________________ Date & reason of last visit: ______________________________

Name: ______________________________ Professional Designation: ______________________________

Clinic Name: ______________________________ Date & reason of last visit: ______________________________

Birth Experience

Location of birth: ◯ Home ◯ Hospital ◯ Birthing Center ◯ Other: ______________________________

Medications during labor/delivery (including IV antibiotics): ◯ Yes ◯ No

Was Pitocin used to induce / speed up labor? ◯ Yes ◯ No

Was your child at any time during pregnancy in a constrained position? ◯ Yes ◯ No ◯ Unsure

If yes, please describe: ◯ Breach ◯ Transverse ◯ Face / Brow Presentation

Was your delivery vaginal or C-Section? ◯ Vaginal ◯ C-Section

If it was vaginal, was the baby presented: ◯ head ◯ face ◯ breech

Were any of the following interventions used? ◯ Forceps ◯ Vacuum Extraction ◯ Other: ________________

Were there any complications during delivery? ◯ Yes ◯ No

If yes, please specify: ____

Was the baby born with any purple markings / bruising on their face or head? ◯ No ◯ Yes: ________________

Any concerns about misshapen head at birth? ◯ Yes ◯ No

Post Natal & Infant History

How many weeks gestation was the baby at birth? ________________ Weight? _________ Length? ___________

Was the baby ever admitted to the NICU? ◯ Yes ◯ No

If yes, for how long and why? ____

Were there any medications given to the baby at birth? ◯ Yes, __________________________________ ◯ No

Was your child exclusively breastfed? ◯ Yes, for _____ months ◯ No

Was your child breastfed + formula fed? ◯ Yes, for ______ months ◯ No

Did your child show any sensitivities to formula (reflux, eczema, arching back)? ◯ Yes ◯ No

Have you chosen for your child to be vaccinated? ◯ Yes (Full) ◯ Yes (Partial) ◯ Yes (Delayed) ◯ No

Physical Trauma

Has your child ever fallen from any high places? ◯ No ◯ Yes

Has your child ever been involved in a motor vehicle accident? ◯ No ◯ Yes

Has your child ever broken any bones? ◯ No ◯ Yes

Has your child had any previous hospitalizations? ◯ No ◯ Yes

Has your child had any previous surgeries? ◯ No ◯ Yes

Does your child use a tablet/computer/video game/phone? ◯ Never ◯ Rarely ◯ Occasionally ◯ Daily

Does your child watch TV? ◯ Never ◯ Rarely ◯ Occasionally ◯ Daily

Does your child exercise? ◯ Never ◯ Rarely ◯ Occasionally ◯ Daily

Does your child play contact sports? ◯ Never ◯ Rarely ◯ Occasionally ◯ Daily

Goals & Consent

Do you feel your child is developmentally appropriate for their age?

Intellectually: ◯ Yes ◯ No, ____

Emotionally: ◯ Yes ◯ No, ____

Physically: ◯ Yes ◯ No, ____

What is your primary goal for your child in this office? ____

VITAL PERFORMANCE CHIROPRACTIC

Our goals are to provide a detailed assessment of your child's current status and provide to you the resources for a highly engaged and healthy child whose body is functioning at its absolute peak potential while they grow. Essential to this healthy growth is a nervous system functioning free from interference called subluxations. You've taken an important step for your child's future through a chiropractic evaluation!

Informed Consent for Chiropractic Care

Chiropractic care, like all forms of health care while offering considerable benefits may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases, injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include sprain/strain injuries, irritation of a disc condition, and rarely, fractures. One of the rarest complications associated with chiropractic care occurring at a rate between one instance per one million to one per two million cervical spine (neck) adjustments may be a vertebral injury that could lead to a stroke.

Prior to receiving chiropractic care in the chiropractic office, a health history and physical examination will be completed. These procedures are performed to assess your specific conditions, your overall health and your spinal health. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies are needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant finding will be reported to you along with a care plan prior to beginning care.

I understand and accept that there are risks associated with chiropractic care and give consent to the examination that the doctor deems necessary and the chiropractic care, including spinal adjustments, as reported following my assessment.

I authorize and request payment of insurance benefits directly to Dr. Dustin Bosson D.C. I agree that this authorization will cover all services rendered until I revoke the authorization. I agree that a photocopy of this form may be used in place of the original. All professional services rendered are charged to the practice member. It is customary to pay for services when rendered unless other arrangements have been made in advance. I understand that I am financially responsible for charges not covered by this assignment.

*Guardian Print Name : ____

*Guardian Signature :____ *Date: ___________________________

Written Consent for A Child

Name of practice member who is a minor/child:____

I authorize Dr. Dustin Bosson and any and all Vital Performance Chiropractic staff to perform diagnostic procedures, radiographic evaluations, render chiropractic care and perform chiropractic adjustments to my minor/child. As of this date, I have the legal right to select and authorize health care services for my minor/child. If my authority to select and authorize care is revoked or altered, I will immediately notify Vital Performance Chiropractic.

Guardian Signature:____Date: ____________________________

Relationship to minor/child: ____

Financial Policy

As a courtesy, Vital Performance Chiropractic verifies your benefits with your insurance company. A quote of benefits is not a guarantee of benefits or payment. Your claim will process according to your plan, if your claim processes differently from the benefits we were quoted, the insurance company will side with the plan and will not honor the benefit quote we received. It is the policy of Vital Performance Chiropractic that payment is due at the time of service unless other financial arrangements are made in advance. We require all patients to pay their deductible, copay and/or coinsurance payment at the beginning of each visit. The office manager at your location will explain this information to you prior to your first visit. At the conclusion of your visits, you may be billed for any outstanding balances. If there is a credit, you will be provided a refund promptly. If you are covered by health insurance with chiropractic benefits, we will be happy to bill your insurance. Please provide your insurance information to the front office staff and we will verify your coverage as a courtesy. Accepting your insurance does not place all financial responsibilities onto this practice, and you will be held accountable for any unpaid balances by your plan. All above guidelines apply to patients seeking to pay out of pocket as well. Vital Performance Chiropractic reserves the right to place a 25% late fee on all unpaid balances after 60 days of non- payment to cover their costs of a collection's agency.

Release of Authorization/Assignment of Benefits

I authorize and request payment of insurance benefits directly to Dustin Bosson DC. I agree that this authorization will cover all services rendered until I revoke the authorization. I agree that a photocopy of this form may be used in place of the original. All professional services rendered are charged to the patient. It is customary to pay for services when rendered unless other arrangements have been made in advance. I understand that I am financially responsible for charges not covered by this assignment.
I acknowledge and agree to the above terms and regulations and certify that I, myself, will be responsible for fees accrued in this office.

*Guardian Signature:____Date:________________________

Notice of Privacy Practices Acknowledgement

I understand that I have certain rights of privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA). I understand that this information can and will be used to:

1. Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations, such as quality assessments and physician's certifications.

I acknowledge that I may request your NOTICE OF PRIVACY PRACTICES containing a more complete description of the uses and disclosures of my health information. I also understand that I may request, in writing, that you restrict how my private information is used to disclose to carry out treatment, payment, or healthcare operation. I also understand you are not required to agree to my requested restrictions, but if you agree, then you are bound to abide by such restrictions.

*Guardian Signature:____ *Date:_______________________

Terms of Acceptance

In order to provide for the most effective healing environment, most effective application of chiropractic procedures, and the strongest possible doctor-practice member relationship, it is our wish to provide each practice member with a set of parameters and declarations that will facilitate the goal of optimum health through chiropractic.

To that end, we ask that you acknowledge the following point regarding chiropractic care and the services that are offered through this clinic :

A. Chiropractic is a very specific science, authorized by law to address spinal health concerns and needs. Chiropractic is a separate and distinct science, art and practice. It is not the practice of medicine.
B. Chiropractic seeks to maximize the inherent healing power of the human body by restoring normal nerve functions through the adjustment of spinal subluxation(s). Subluxations are deviations from normal spinal structures and configurations that interfere with normal nerve process.
C. The chiropractic adjustment process, as defined in the law of this jurisdiction, involves the application of a specific directional thrust to a region or regions of the spine with the specific intent of re-positioning misaligned spinal segments. This is a safe, effective procedure applied over one million times each day by doctors of chiropractic in the United States alone.
D. A thorough chiropractic examination and evaluation is part of the standard chiropractic procedure. The goal of this process is to identify any spinal health problems and chiropractic needs. If during this process, any condition or question outside the scope of chiropractic is identified, you will receive a prompt referral to an appropriate provider or specialist, according to the initial indications of need.
E. Chiropractic does not seek to replace or compete with your medical, dental, or other type(s) of health professionals. They retain responsibility for care and management of medical conditions. We do not offer advice regarding treatment prescribed by others.
F. Your compliance with care plans, home and self-care, etc., is essential to maximum healing and optimal health through chiropractic.
   - We invite you to speak frankly to the doctor on any matter related to your care at this facility, its nature, duration, or cost, in what we work to maintain as a supporting, open environment.

By my signature below, I have read and fully understand the above statements.
All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my satisfaction. I therefore accept chiropractic care on this basis.

*Guardian Signature:____ *Date: _______________________

X-Ray Authorization

As your healthcare provider, we are legally responsible for your chiropractic records. We must maintain a record of your x-rays in our files. At your request, we will provide you with a copy of your x-rays in our files. Digital x-rays on a CD or USB will be available within 72 business hours for the customary charge of supplies and time required for copying. Please note x-rays are utilized in this office to help locate and analyze vertebral subluxations. The doctors of Vital Performance Chiropractic do not diagnose or treat medical conditions; however, if any abnormalities are found, we will bring it to your attention so that you can seek proper medical advice. By signing below you are agreeing to the above terms and conditions.

*Guardian Print Name:_______________________________________ *Date of Birth: ______________

*Guardian Signature:____ *Date:___________________

FEMALES ONLY: To the best of my knowledge, **I BELIEVE I AM NOT PREGNANT at the time the x-rays are taken at Vital Performance Chiropractic.**

*Guardian Signature:____ *Date: __________________