HONEYBEE CHIROPRACTIC

Pediatric Patient Intake Form

Today's Date: _____ *To be filled out by parent or guardian completely*

Child's Name: _____

Date of Birth: _____ Male/Female

Address: _____ City: _____ State: _____ Zip :_____

Parent/Guardian Name:_____

Phone:_____ Email:_____

How did you hear about us? _____

Health Information:

What is the main reason for your initial visit today: _____

Please explain:_____

_____

Please list any important health history or problems: _____

_____

_____

Please list any other doctors/providers your child is seeing and conditions treated: _____

_____

Current medications and/or supplements:_____

_____

Please list any past surgeries and dates: _____

Past accidents and dates:_____

Have any x-rays been taken in the last 2 years? _____

Chiropractic History

Has your child been to a chiropractor before? Yes/No

If yes, doctor's name and when:_____

Is there any other information you feel would help with the care of your child?

_____

_____

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Goals

HoneyBee Chirporactic is dedicated to providing the best care possible to help you acheive your goals. With objective goals, we are able to measure progress and results.

What would you like to see happen or be able to do with the help of chirorpactic care?

Better Focus	**Improved Athletic Performance**	**Less Anxiety**
Better Sleep	**More Energy**	**Less Sick Days (Immune System)**
Less Ear Infections	**Better Digestion**	**Less Pain**

What are your main goals:

1. _____
2. _____
3. _____

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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 million to one instance per two million cervical spine (neck) adjustments may be a vertebral artery injury that could lead to a stroke.

Prior to receiving chiropractic care in this chiropractic office, a health history and physical examination will be completed. These procedures are performed to assess your specific conditions, your overall health, and in particular 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 findings 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.

If patient is a minor/child, parent or guardian must sign below

Patients Name: _____

Guardian Signature: _____ Date: _____

Guardian Relationship to minor/child: _____

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Written Consent for a Child

I authorize any and all 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 the practice.

Patients Name: _____

Guardian Signature: _____ Date: _____

Guardian Relationship to minor/child: _____

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:

Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involvedin that treatment directly and indirectly.
Obtain payment from third-party payers.
Conduct normal healthcare operations, such as quality assessments and physicians 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 or disclosed 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: _____

HONEYBEE CHIROPRACTIC

Terms of Acceptance

In order to provide the most effective healing environment, most effective application of chiropractic procedures, and the strongest possible doctor-patient relationship, it is our wish to provide each patient 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:

1. **Chiropractic care 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.**
2. **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 processes.**
3. **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.**
4. **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 the need.**
5. **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.**
6. **Your compliance with care plans, home and self-care, etc. is essential to maximum healing and optimal health through chiropractic.**
7. **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.

Patients Name: _____

Guardian Signature: _____ Date: _____

Guardian Relationship to minor/child: _____