HARBOR CHIROPRACTIC

Pediatric New Patient Intake Form – Bradenton

CONTACT INFORMATION

Name_____ Preferred to be called _____ □ Male □ Female

Address_____ City_____ State_____ Zip_____ Date of Birth _____

Home Phone_____ Cell Phone_____ E-mail _____

SSN_____ Marital Status: S M D W Spouse's Name: _____

Primary Care Physician_____ Preferred Language _____ Race/Ethnicity: _____

Emergency Contact _____ Phone Number _____ Relationship _____

How were you referred you to our office? _____

Occupation_____ Employer_____

BILLING INFORMATION □ Self Pay

Please check any and all insurance coverage that may be applicable in this case:

□ Major Medical □ Medicare □ Auto Accident □ Medical Savings Account & Flex Plans □ Other

Insurance Company Name _____

Insured's Name _____ Insured's DOB _____

Name of Secondary Insurance Company (if any) _____

If you are not financially responsible for your account, who is?

Name:_____ Phone:_____

Authorization and Release: I authorize RHC Health Services, LLC d/b/a Harbor Chiropractic to release any information pertinent to my case to my insurance carrier and to submit a claim for all services rendered by this office. I authorize and direct my insurance carrier or its intermediaries to issue payment checks directly to this office for services rendered. I understand I am financially responsible to this office for any balance, regardless of insurance coverage. I understand that if I suspended or terminate my care and treatment, any fees for professional services rendered will be immediately due and payable. If it is necessary for this office to employ collections counsel, I understand that I am responsible for those collection charges. A copy of this signature is as valid as the original.

Patient Signature: _____Date: _____

(If patient is a minor, signature of parent/guardian)

Authorization for Care of Minor

I hereby authorize Harbor Chiropractic, its Doctor(s) and Staff, to administer chiropractic care to my Son/Daughter/Individual who I have legal guardianship of as they deem necessary. I clearly understand and agree that I am personally responsible for payment of all fees at the time services are rendered. I understand that a guardian shall be aware of/present during all procedures being performed at Harbor Chiropractic.

Patient Signature: _____Date: _____

(If patient is a minor, signature of parent/guardian)

NOTICE OF OUR PRIVACY PRACTICES

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care treatments we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

PLEASE REVIEW THIS NOTICE CAREFULLY

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.

2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.

3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.

4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.

5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.

6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.

7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care. I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Please list who we may speak with regarding your care and account. Please note, we cannot speak with or release any information to anyone not listed: _____

Patient Signature: _____Date: _____

(If patient is a minor, signature of parent/guardian)

CONSENT TO TREAT

I hereby request and consent to the performance of chiropractic adjustments and procedures, including various modes of physio therapy (spinal-decompression, acupuncture, myofascial release, therapeutic exercises, ultrasound therapy, electrical muscle stimulation, graston/gua sha, ect.), diagnostic x-rays, and any supportive therapies (low level laser therapy) on me (or on the patient named below, for whom I am legally responsible) by the doctors of chiropractic and support staff who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor(s) of chiropractic at Harbor Chiropractic, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with the doctor(s) of chiropractic at Harbor Chiropractic and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and therapeutic procedures.

I understand and I am informed that, as is with all healthcare treatments, results are not guaranteed and there is no promise to cure. I further understand and I am informed that, as is with all healthcare treatments, in the practice of chiropractic there are some risks to treatment, including, but not limited to, muscle spasms for short periods of time, aggravating and/or temporary increase in symptoms, fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I further understand that chiropractic adjustments and supportive treatment are designed to reduce and/or correct subluxations allowing the body to return to improved health. It can also alleviate certain symptoms through a conservative approach with hopes to avoid more invasive procedures. However, like all other health modalities, results are not guaranteed and there is no promise to cure. Accordingly, I understand that all payment(s) for treatment(s) are final and no refunds will be issued. However, prorated fees for unused, prepaid treatments will be refunded if I wish to cancel the treatment.

I further understand that there are treatment options available for my condition other than chiropractic procedures. These treatment options include, but not limited self-administered, over the counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; physical therapy; steroid injections; bracing; and surgery. I understand and have been informed that I have the right to have a second opinion and secure other opinions if I have concerns as to the nature of my symptoms and treatment options.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient Signature: _____Date: _____

(If patient is a minor, signature of parent/guardian)

Name: _____ **Date:** _____

Purpose for Contacting our office: _____

Have Other Doctors Been Seen for this Condition? □ Yes □ No
If Yes, List Doctor Name(s) and Prior Treatments: _____

_____

Check Any of the Following Conditions Your Child Has Experienced During the Past Six Months:
□ Ear Infections □ Digestive Problems □ Car Accident □ Headaches □ Asthma / Allergies □ Bed Wetting
□ Chronic Colds □ Growing / Back Pains □ Colic □ Seizures □ Recurring Fevers □ Autism □ Scoliosis
□ ADD/ADHD □ Temper Tantrums □ Other:_____

Social History: Activity Level: □ None □ Light □ Moderate □ Vigorous

Hospitalizations: □ None If yes, list: _____

Surgeries: □ None If yes, list: _____

Prior Accidents/Injuries/Car Accidents: □ None If yes, list: _____

_____

According to the National Safety Council, approximately 50% of children fall head-first from a high place during their first year of life (for example: a bed, changing table, stairs, etc.).
Has your child had a head-first fall? □ Yes □ No

Is/has your child been involved in any high impact or contact sports (i.e., Soccer, Football, Gymnastics, Baseball, Cheerleading, Martial Arts, etc.)? □ Yes □ No List: _____

Childhood Diseases: Please mark all that apply. □ Chicken Pox Age:_____ □ Mumps Age:_____
□ Rubella Age:____ □ Whooping Cough Age:____ □ Rubeola Age:_____ □ Other(s) List:_____

Past Medical History/Current Conditions (Check all that apply to your child) □ **None**

□ Arthritis	□ Cancer	□ Diabetes	□ Heart Disease
□ High Blood Pressure	□ Psychiatric Illness	□ Skin Disorder	□ Stroke
□ Fibromyalgia	□ Asthma	□ Osteoporosis/penia	□ Other _____

Current Medications/Supplements: □ **If yes, List:** _____

Allergies: □ **None If yes, List:** _____

Family History: □ **None**
(check if applicable and indicate **F**ather, **M**other, **S**ister, **B**rother)
Arthritis: _____ Cancer: _____ Diabetes: _____ Heart Disease: _____ Hypertension: _____ Stroke: _____
Other: _____
Check if applicable to your child: ____ As an adopted child, little is known of birth parents or family.

Previous Chiropractic Care: □ Yes □ No Date of last adjustment: _____
Preferred Method of Adjusting (if applicable): □ Manual □ Instrument

Previous Tests: □ **None** □ MRI □ X-Rays □ CT Region, Date, and Results: _____

Name: _____ **Date:** _____

CURRENT COMPLAINT(S):

Please answer each section for each individual symptom. (i.e.: Low back pain and neck pain would be completed separately) If only one symptom, only complete region #1. If more than 2 regions of complaint, please request an additional sheet.

#1: Location on body: _____ **R / L Pain Intensity:** no pain 0 1 2 3 4 5 6 7 8 9 10 worst pain

When did your symptoms begin? _____ **How did they begin?** _____

Are your symptoms a result of: □ Motor Vehicle Accident □ Work Related Accident □ Other_____
Current Open Insurance Claim: □ Yes □ No

How often do you experience your symptoms?
□ Constantly: (76-100% of the day) □ Frequently (51-75% of the day) □ Intermittently (26-50% of the day) □ Occasionally (0-25% of the day)

Is the pain: □ Not applicable
□ Unaffected by time of day? □ Worse in the morning? □ Worse in the afternoon? □ Worse at night

What describes the nature of your symptoms?
□ Ache □ Burning □ Dull □ Sharp □ Stabbing □ Throbbing
□ Weakness □ Numbness/Tingling □ Stiffness □ Other _____ □ Radiates into _____

Does anything aggravate your pain? □ No If yes, check below
□ Activity (circle: Heavy / Light / Moderate) □ Bending □ Lifting □ Standing □ Stress
□ Temperature Changes □ Twisting □ Other _____

Does anything improve your pain? □ No If yes, check below
□ Cold □ Heat □ Activity □ Lying Down □ OTC Medication □ Postural Changes □ Rest
□ Prescribed Medications □ Stretching □ Support Brace □ Adjustments □ Other _____

#2: Location on body: _____ **R / L Pain Intensity:** no pain 0 1 2 3 4 5 6 7 8 9 10 worst pain

When did your symptoms begin? _____ **How did they begin?** _____

Are your symptoms a result of: □ Motor Vehicle Accident □ Work Related Accident □ Other_____
Current Open Insurance Claim: □ Yes □ No

How often do you experience your symptoms?
□ Constantly: (76-100% of the day) □ Frequently (51-75% of the day) □ Intermittently (26-50% of the day) □ Occasionally (0-25% of the day)

Is the pain: □ Not applicable
□ Unaffected by time of day? □ Worse in the morning? □ Worse in the afternoon? □ Worse at night

What describes the nature of your symptoms?
□ Ache □ Burning □ Dull □ Sharp □ Stabbing □ Throbbing
□ Weakness □ Numbness/Tingling □ Stiffness □ Other _____ □ Radiates into _____

Does anything aggravate your pain? □ No If yes, check below
□ Activity (circle: Heavy / Light / Moderate) □ Bending □ Lifting □ Standing □ Stress
□ Temperature Changes □ Twisting □ Other _____

Does anything improve your pain? □ No If yes, check below
□ Cold □ Heat □ Activity □ Lying Down □ OTC Medication □ Postural Changes □ Rest
□ Prescribed Medications □ Stretching □ Support Brace □ Adjustments □ Other _____

If there are MORE regions of complaint, please request additional sheet from one of our chiropractic assistants.

Name: _____ **Date:** _____

Review of Systems (Check box if you have/have had trouble with any of the following. Leave blank if not applicable)

General	**Have**	**Had**	**HEENT**	**Have**	**Had**	**Skin/Hair**	**Have**	**Had**
Lethargy/Weakness			Headaches/Migraines			Rashes/Skin Trouble		
Recurring Fever			Eye/Vision Problem			Flushing		
Weight Loss/Gain			Nose Bleeds			Excess Acne		
Dizziness			Sore Throat			Eczema		
Fever			Hoarseness			Psoriasis		
Chills			Swollen glands			Skin Cancer		
			Sinus Trouble			Skin Color Change		
Cardiovascular:			Ear/Hearing Problem			Change in hair/nail		
Chest Pain/Pressure			Dental Problems			Easy Bruising		
Heart Attack			TMJ Problems					
Shortness of Breath						**Gastrointestinal**		
Palpitations			**Respiratory**			Loss of Appetite		
Swelling hands/feet			Chronic Cough			Nausea/Vomiting		
Hypertension (HBP)			Asthma/Wheezing			Diarrhea		
High Cholesterol			Short of Breath			Constipation		
Heart Murmur			Exercise Intolerance			Abdominal Pain		
Blood Clots			Sleep Apnea			Ulcers		
Pacemaker			Emphysema			Bloating/Cramping		
Mitral Valve Prolapse						Heartburn		
			Musculoskeletal			Hemorrhoids		
Neurologic			Arthritis			Hepatitis		
Frequent Headache			Joint Pain/Swell			Cirrhosis		
Migraines			Neck Pain			Gastric Reflux		
Dizziness			Back Pain			Bowel/Bladder Issues		
Fainting			Trauma					
Memory Loss			Osteoporosis			**Blood/Lymph**		
Poor Balance			Scoliosis			Anemia		
Numbness/tingling			Cramping			Bleeding		
Pins/Needles						Bruising		
Muscle Weakness			**Endocrine**			Blood Clots		
Seizures			Diabetes			Past Transfusions		
Stroke			Thyroid Problems			Leukemia		
Tremors			Sweating			Lymphoma		
Head Injury			Hot/Cold Intolerance			HIV/AIDS		
			Weight Loss			Sickle Cell		
Psychiatric			Weight Gain					
Insomnia			Excess Urination			**Urinary**		
Diff Concentrating			Excess thirst			Excess/Pain Urination		
Memory Loss/Confusion			Appetite Change			Incontinence		
Depression						Urgency		
Anxiety			**Female**			Kidney Stones		
Agitation/Irritability			Menstrual Irregularity					
			Hot Flashes			**Male**		
Allergies			Breast Pain/Lumps			Testicular Pain/Lumps		
Seasonal			Menopause			Prostate Disease		
Food								
Medication								

Name: _____ **Date:** _____

Rate your current difficulties by placing the appropriate number in the box (below; a **1 / 2 / 3**). NO check marks! If an activity does not cause pain or if pain does not affect an activity, leave box **blank**.

[1] This activity causes some pain, but it is of minor annoyance.
[2] This activity causes a significant amount of pain.
[3] I cannot perform this activity due to pain and disability.

Self-Care and Personal Hygiene: ___bathing ___brushing teeth ___putting on shoes ___doing laundry ___grooming hair ___making bed ___putting on pants ___doing dishes ___washing face ___putting on shirt ___cooking ___taking out trash ___going to bathroom or sitting on toilet

Physical Activities: ___standing ___walking ___reaching ___bending right ___twisting right ___sitting ___squatting ___bending ___bending left ___twisting left ___reclining ___bending back ___kneeling ___looking left ___looking right

Functional Activities: ___carrying small objects ___lifting weight off table ___push/pull standing ___carrying large objects ___climbing stairs/incline ___exercising upper body ___exercising lower body ___carrying purse/case ___lifting objects off floor ___push/pull seated

Social & Recreational Activities: ___jogging ___biking ___swimming ___dancing ___golfing ___bowling ___hunting ___fishing ___gardening ___basketball ___soccer ___hockey ___competitive sports

Difficulties with Travel: ___driving in car ___riding as passenger ___entering and exiting vehicle ___driving for long periods of time ___riding as passenger for long period of time

Other Activities: ___concentrating ___studying ___listening ___reading ___writing ___using computer ___sleeping ___sexual relation

How does your condition interfere with the things you do every day? Please think about the 4 following areas and make notes on how these daily activities have been affected since the condition began.

HOME: _____

_____

WORK: _____

_____

RECREATION: _____

_____

PERSONAL LIFE: _____

_____

Name: _____ **Date:** _____

NECK PAIN (if applicable)

Neck Disability Index

This questionnaire has been designed to give the doctor information as to how your NECK pain has affected your ability to manage in everyday life. In each section, please circle the choice which **most closely** describes your problem.

Section 1 – Pain Intensity

- ❑ I have no pain at the moment.
- ❑ The pain is mild at the moment.
- ❑ The pain comes and goes and is moderate.
- ❑ The pain is moderate and does not vary much.
- ❑ The pain is very severe but comes and goes.
- ❑ The pain is severe and does not vary much.

Section 2 – Personal Care (Washing, Dressing, etc.)

- ❑ I can look after myself normally without causing extra pain.
- ❑ I can look after myself normally, but it causes extra pain.
- ❑ It is painful to look after myself and I am slow and careful.
- ❑ I need some help but manage most of my personal care.
- ❑ I need help every day in most aspects of self-care.
- ❑ I do not get dressed, wash with difficulty and stay in bed.

Section 3 – Lifting

- ❑ I can lift heavy weights without extra pain.
- ❑ I can lift heavy weights, but it gives extra pain.
- ❑ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example on a table.
- ❑ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ❑ I can only lift very light weights.
- ❑ I cannot lift or carry anything at all.

Section 4 – Reading

- ❑ I can read as much as I want to with no neck pain.
- ❑ I can read as much as I want to with slight neck pain.
- ❑ I can read as much as I want with moderate neck pain.
- ❑ I cannot read as much as I want because of moderate neck pain.
- ❑ I cannot read as much as I want because of severe neck pain.
- ❑ I cannot read at all.

Section 5 – Headaches

- ❑ I have no headaches at all.
- ❑ I have slight headaches that come infrequently.
- ❑ I have moderate headaches which come infrequently.
- ❑ I have moderate headaches which come frequently.
- ❑ I have severe headaches which come frequently.
- ❑ I have headaches almost all the time.

Section 6 – Concentration

- ❑ I can concentrate fully when I want to with no difficulty.
- ❑ I can concentrate fully when I want to with slight difficulty.
- ❑ I have a fair degree of difficulty in concentrating when I want to.
- ❑ I have a lot of difficulty in concentrating when I want to.
- ❑ I have a great deal of difficulty in concentrating when I want to.
- ❑ I cannot concentrate at all.

Section 7 – Work

- ❑ I can do as much work as I want to.
- ❑ I can do my usual work, but no more.
- ❑ I can do most of my usual work, but no more.
- ❑ I cannot do my usual work.
- ❑ I can hardly do any work at all.
- ❑ I cannot do any work at all.

Section 8 – Driving

- ❑ I can drive my car without any neck pain.
- ❑ I can drive my car as long as I want with slight neck pain.
- ❑ I can drive my car as long as I want with moderate pain
- ❑ I cannot drive my car as long as I want because of moderate pain in my neck.
- ❑ I can hardly drive at all because of severe neck pain.
- ❑ I cannot drive my car at all.

Section 9 – Sleeping

- ❑ I have no trouble sleeping.
- ❑ My sleep is slightly disturbed (< 1 hour sleepless).
- ❑ My sleep is mildly disturbed (1-2 hours sleepless).
- ❑ My sleep is moderately disturbed (2-3 hours sleepless).
- ❑ My sleep is greatly disturbed (3-5 hours sleepless).
- ❑ My sleep is completely disturbed (5-7 hours sleepless).

Section 10 – Recreation

- ❑ I am able to engage in all my recreation activities with no neck pain at all.
- ❑ I am able to engage in all my recreation activities, with some pain in my neck.
- ❑ I am able to engage in most, but not all, of my usual recreation activities because of pain in my neck.
- ❑ I am able to engage in a few of my usual recreation activities because of pain in my neck.
- ❑ I can hardly do any recreation activities because of pain in my neck.
- ❑ I cannot do any recreation activities at all

Name: _____ **Date:** _____

LOWER BACK PAIN (if applicable)

Oswestry Disability Index

This questionnaire has been designed to give the doctor information as to how your low back pain has affected your ability to manage in everyday life. In each section, please circle the choice which **most closely** describes your problem.

Section 1 – Pain Intensity
- ❑ I have no pain at the moment.
- ❑ The pain is very mild at the moment.
- ❑ The pain is moderate at the moment.
- ❑ The pain is fairly severe at the moment.
- ❑ The pain is very severe at the moment.
- ❑ The pain is the worst imaginable at the moment.

Section 2 – Personal Care(washing, dressing, etc)
- ❑ I can look after myself normally, without causing extra pain.
- ❑ I can look after myself normally but it causes extra pain.
- ❑ It is painful to look after myself and I am slow and careful.
- ❑ I need some help but manage most of my personal care.
- ❑ I need help every day in most aspects of self-care.
- ❑ I do not get dressed, wash with difficulty, and stay in bed.

Section 3 - Lifting
- ❑ I can lift heavy weights without extra pain.
- ❑ I can lift heavy weights, but it gives extra pain.
- ❑ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (i.e. on a table).
- ❑ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ❑ I can lift only very light weights.
- ❑ I cannot lift or carry anything.

Section 4 – Walking
- ❑ Pain does not prevent me walking any distance.
- ❑ Pain prevents me walking more than 1mile.
- ❑ Pain prevents me walking more than 1/2 of a mile.
- ❑ Pain prevents me walking more than 100 yards.
- ❑ I can only walk using a stick or crutches.
- ❑ I am in bed most of the time.

Section 5 – Sitting
- ❑ I can sit in any chair as long as I like.
- ❑ I can sit in my favorite chair as long as I like.
- ❑ Pain prevents me from sitting for more than 1 hr.
- ❑ Pain prevents me from sitting for more than 30 min.
- ❑ Pain prevents me from sitting for more than 10 min.
- ❑ Pain prevents me from sitting at all.

Section 6 – Standing
- ❑ I can stand as long as I want without extra pain.
- ❑ I can stand as long as I want but it gives me extra pain.
- ❑ Pain prevents me from standing more than 1 hour.
- ❑ Pain prevents me from standing for more than 30 min.
- ❑ Pain prevents me from standing for more than 10 min.
- ❑ Pain prevents me from standing at all.

Section 7 – Sleeping
- ❑ My sleep is never disturbed by pain.
- ❑ My sleep is occasionally disturbed by pain.
- ❑ Because of pain, I have less than 6 hours sleep.
- ❑ Because of pain, I have less than 4 hours sleep.
- ❑ Because of pain, I have less than 2 hours sleep.
- ❑ Pain prevents me from sleeping at all.

Section 8 – Sex life (if applicable)
- ❑ My sex life is normal and causes no extra pain.
- ❑ My sex life is normal but causes some extra pain.
- ❑ My sex life is nearly normal but is very painful.
- ❑ My sex life is severely restricted by pain.
- ❑ My sex life is nearly absent because of pain.
- ❑ Pain prevents any sex life at all.

Section 9 – Social Life
- ❑ My social life is normal and cause me no extra pain.
- ❑ My social life is normal but increases the degree of pain.
- ❑ Pain has no significant effect on my social life apart from limiting my more energetic interests, i.e. sport.
- ❑ Pain has restricted my social life and I do not go out as often.
- ❑ Pain has restricted social life to my home.
- ❑ I have no social life because of pain.

Section 10 – Traveling
- ❑ I can travel anywhere without pain.
- ❑ I can travel anywhere but it gives extra pain.
- ❑ Pain is bad but I manage journeys of over 2 hours.
- ❑ Pain restricts me to journeys of less than 1 hour.
- ❑ Pain restricts me to short necessary journeys under 30 min.
- ❑ Pain prevents me from traveling except to receive treatment.