

INTAKE PAPERWORK AGES 5 through 13 YEARS OLD

Today's Date: ____ / ____ / ____

Name: _____

Date of Birth: ____ / ____ / ____ Age: _____ Gender: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Family Status: _____

Parent/Guardian 1: _____

Preferred Phone: (____) _____ - _____ Occupation: _____

Email Address: _____

Parent/Guardian 2: _____

Preferred Phone: (____) _____ - _____ Occupation: _____

Email Address: _____

With whom and how should we be in touch regarding your child's care?

Parent/Guardian _____ Text/Call/Email _____

Whom may we thank for referring you to KIDSPACE: _____

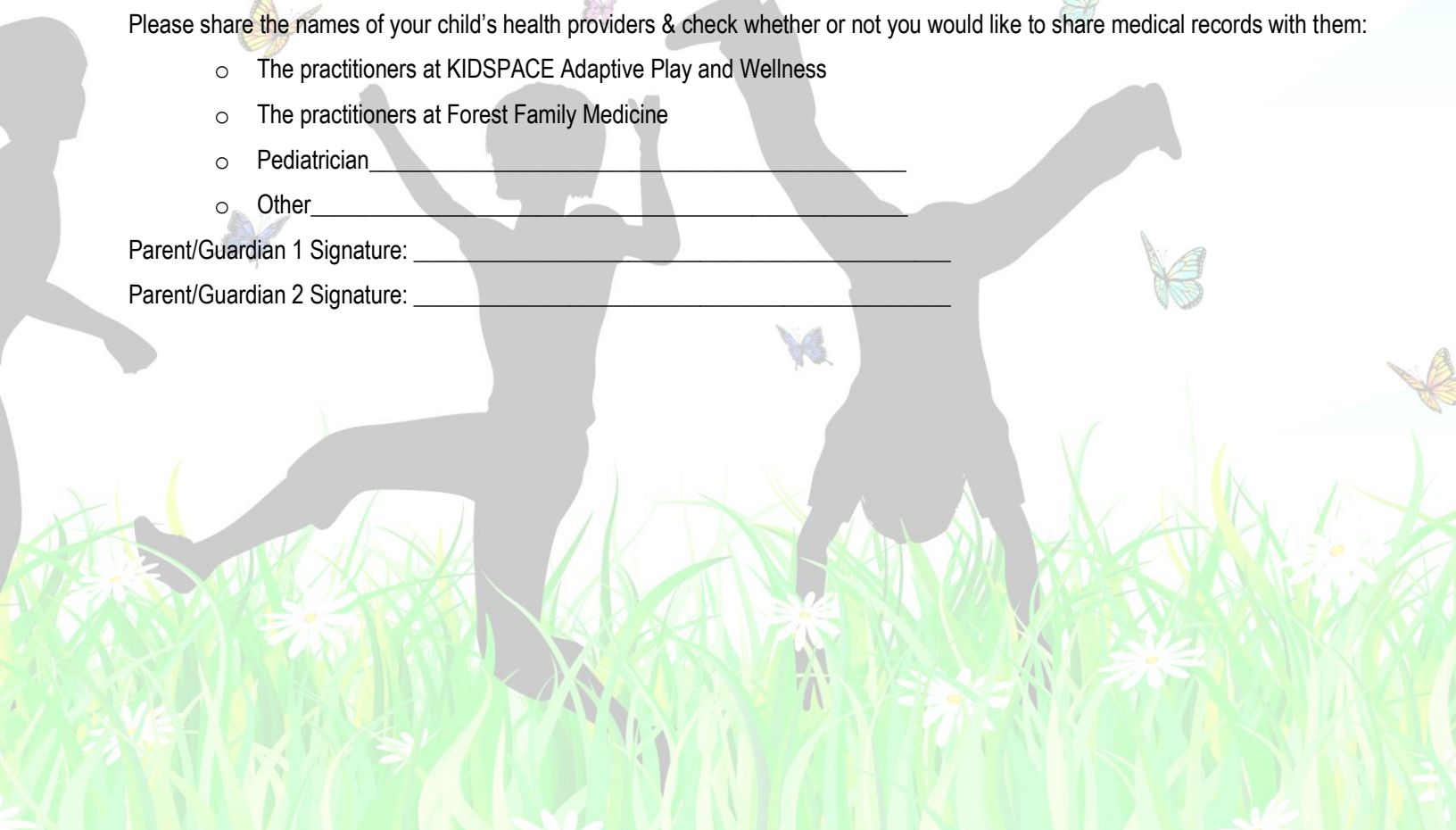
CONSENT TO SHARE MEDICAL AND EDUCATIONAL RECORDS AND/OR DISCUSS MEDICAL HISTORY

Please share the names of your child's health providers & check whether or not you would like to share medical records with them:

- The practitioners at KIDSPACE Adaptive Play and Wellness
- The practitioners at Forest Family Medicine
- Pediatrician _____
- Other _____

Parent/Guardian 1 Signature: _____

Parent/Guardian 2 Signature: _____



CURRENT CONCERNS

Please list your concerns about your child in order of importance:

1. _____
2. _____
3. _____
4. _____

What are his/her current symptoms: _____

When did they begin? _____

How did they begin? _____

Has he/she had any treatment for these symptoms? _____

What are you goals for your child's care at KIDSPACE?

Describe your child in your own words:

PREGNANCY and LABOR

Mom's age when baby was born? _____ How many pregnancies? _____ Live births? _____

Any problems conceiving? _____ Treatment? _____

How was pregnancy overall? _____

During pregnancy was mom on medication (over the counter/prescribed/recreational)?

During pregnancy did mom smoke or consume any alcoholic beverages? _____

Was mom in pain during pregnancy? _____

Was mom physically ill? (colds, flu, allergies, German measles, etc.) _____

Was labor chemically induced? _____ Doctor assisted? _____

Approximately how long was labor? _____ Who was present? _____

C-section? _____ Were forceps/vacuum used? _____

Did doctor have hands on the child? _____ What position was mom in? _____

Any time in NICU? _____ Why? _____ How long? _____

What was baby's gestational age? _____ Length? _____ Weight? _____ Head circumference? _____

Baby's APGARs: _____ 1 min _____ 5 min; Any problems at birth? _____

Did mom breastfeed? _____ Any problems? _____ How long? _____

Did mom bottlefeed? _____ What formula? _____ Any problems? _____

Did mom see a lactation consultant in hospital? _____ Who? _____

Did mom see a lactation consultant privately? _____ Who? _____

MEDICAL HISTORY

Please describe any major illnesses, previous diagnoses, hospitalizations, surgeries, major accidents/injuries, x-rays, CAT scans, MRIs, EKGs, etc. :

Date	Description

Please list any known allergies (drugs, food, environmental, chemical, etc) and the reactions from them:

Please list any and all current medications (prescription and over-the counter) & supplements including (vitamins, herbs, homeopathic remedies):

Name of Drug/Supplement	Date Started	Dosage/Frequency	Prescribed for:

Does your child have any of the following?

- | | | |
|---|---|---|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Asthma | <input type="checkbox"/> Bedwetting |
| <input type="checkbox"/> Bloody Noses | <input type="checkbox"/> Frequent Colds | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Congestion | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Digestive Problems |
| <input type="checkbox"/> Ear Problems | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Flu |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> Irritability |
| <input type="checkbox"/> Learning Disorders | <input type="checkbox"/> Milk/Lactose Intolerance | <input type="checkbox"/> Meningitis |
| <input type="checkbox"/> Menses | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Poor posture |
| <input type="checkbox"/> Rashes | <input type="checkbox"/> Sleeping Disorders | <input type="checkbox"/> Snoring/Apnea |

Other _____

Please describe your child's habits as good, fair or poor:

- | | | |
|-------------|----------------|-------------------------|
| Bowel _____ | Eating _____ | Listening _____ |
| Mood _____ | Sleeping _____ | Physical Strength _____ |

Has your child had any of the following illnesses?

- | | | |
|-----------------|-----------------------|-------------------------------|
| _____ Measles | _____ German Measles | _____ Mumps |
| _____ Pneumonia | _____ Scarlet Fever | _____ Chicken Pox |
| _____ Cancer | _____ Rheumatic Fever | _____ Urinary Tract Infection |
| _____ RSV | _____ Rotavirus | _____ Strep Throat |
| _____ HIV/AIDS | _____ Tuberculosis | _____ Other Illnesses |

Has your child had any extensive dental work, extractions or orthodonture?

Does your child have difficulty with food textures, chewing, or swallowing solids or liquids?

DEVELOPMENTAL INFORMATION

Please indicate which important milestones your child has attained. If he/she was late please indicate.

- Sitting up _____
- Crawling _____
- Walking _____
- Talking _____
- Skipping _____
- Standing on one foot _____
- Catching a ball _____
- Socializing _____

Is there anything you would like to tell us about your child's development thus far?

SCHOOL AND SOCIAL HISTORY

Is your child home-schooled or enrolled in a traditional public, private, or special school?

Does your child experience stress from school work load? _____

- Academic performance? _____
- Peers? _____
- Athletic performance _____
- Other interests? _____

Does your child have sensory sensitivities?

Difficulties with Coordination?

IMMUNIZATION RECORD

Please record the date of each immunization given to your child.

Vaccine	Date Given (m/d/yy)	Vaccine	Date Given (m/d/yy)
Hepatitis B		Hepatitis A	
Diphtheria, Tetanus, Pertussis boosters		Meningococcal	
		Human papillomavirus	
		Zoster (shingles)	
		Influenza (yearly)	
<i>Haemophilus influenzae</i> type b			
Pneumococcal		Other	
Polio			
Rotavirus			
Measles, Mumps, & Rubella			
Varicella (chickenpox)			

Is your child up to date on all immunizations? Yes No

Please list any adverse reactions to immunizations. Please be specific.

Were these reactions reported to VAERS? Yes No

FAMILY MEDICAL HISTORY

	Mother	Father	Brothers	Sisters	Maternal/Paternal Grandparents	Aunts/Uncles
<i>Check if applicable</i>						
Cancer						
Diabetes						
Heart Disease						
High Blood Pressure						
Stroke						
Epilepsy						
Mental Illness						
Asthma						
Kidney Disease						
Autoimmune Disease						
Other						



CONSENT FOR TREATMENT OF A MINOR

We, the parents or guardians, consent to the treatment/procedure rendered to our child or ward under general and specific instructions of my child's health care provider including but not limited to chiropractic, CranioSacral therapy, massage, sensory processing, or recreational therapy, as well as nutritional, homeopathic and herbal therapies and whole health counseling. We have had the mechanisms and risks of chiropractic adjustments based on pediatric anatomy and physiology explained to our satisfaction and authorize said treatment on the above-named child understanding the risks and incidence of deleterious effect. We recognize that even the gentlest therapies may potentially have complications in very young children, in the elderly, or in those on multiple medications. Hence, the information we have provided our health care providers is complete and inclusive of all health concerns and medications, including over-the-counter medications, supplements, and herbs our child may be taking. With this knowledge, we voluntarily consent to the proposed procedures. We acknowledge that no guarantees of cure or improvement of condition have been made. We understand that we are free to withdraw consent and to discontinue treatment at any time. We attest that we are the legal parent(s)/guardian(s) and are designated and authorized to make healthcare decisions and consent to healthcare for this child.

You are responsible for informing our providers of any relevant information or changes that affect your child's health. Should privileged information be shared via text message or email, your provider will make every effort to maintain privacy but text messaging and emailing are not encrypted or HIPAA-approved means of communication.

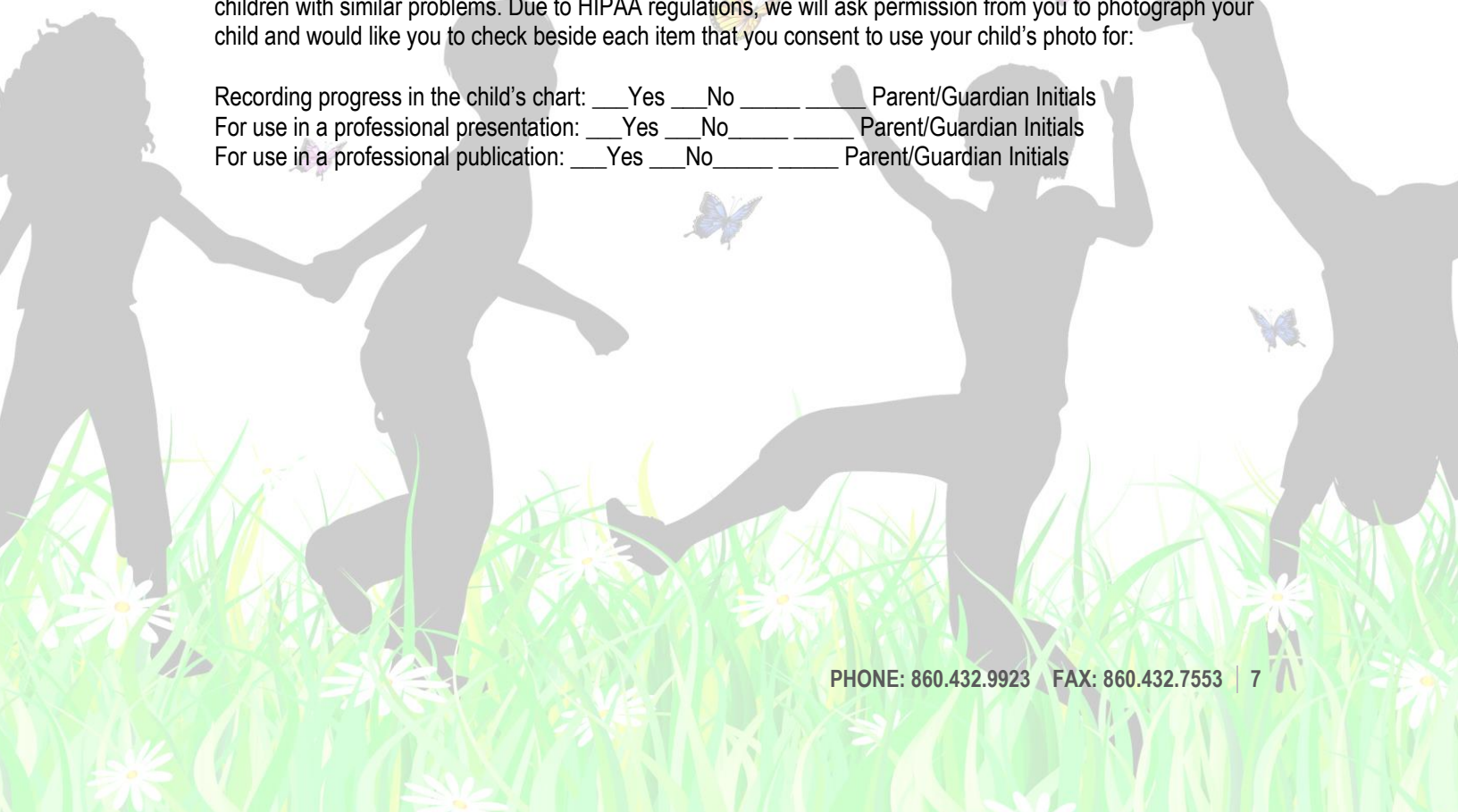
Parent/Guardian Signature 1 Date

Parent/Guardian Signature 2 Date

CONSENT TO PHOTOGRAPH

Photographs of your child help us see changes and help us teach other health care providers about caring for children with similar problems. Due to HIPAA regulations, we will ask permission from you to photograph your child and would like you to check beside each item that you consent to use your child's photo for:

- Recording progress in the child's chart: Yes No _____ Parent/Guardian Initials
- For use in a professional presentation: Yes No _____ Parent/Guardian Initials
- For use in a professional publication: Yes No _____ Parent/Guardian Initials



PARENT RESPONSIBILITIES

We agree to be financially responsible for all charges incurred at this office. We will make payment as required at the time of service. Should collection efforts be necessary to collect money owed, **a 15% interest charge will be added to the balance due.** We are liable for any cost incurred by the office in collection efforts.

CANCELLATION POLICY

If you are unable to make your appointment, please provide at least 24-hour notice of cancellation. **A cancellation fee of \$50 will apply for appointments cancelled with less than 24-hour notice.**

Signature

Date

Our office requires a credit card to be kept on file for any charges incurred.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

This document is to be signed by persons legally responsible for the patient’s medical decisions relative to the treatment situation.

We, _____, hereby acknowledge that we have been provided with a copy of the Notice of Privacy Practices that describes how medical information about our child/guardian may be used and disclosed, and how we can access that information. We understand that if we have questions or complaints, I may contact: **Faraneh Carnegie-Hargreaves, DC, Karen Peck CTRS, CST, QST; Sharon A. Vallone, DC, FICCP; or Lindsey Wells, ND at 860.432.9923.**

We also understand that we are entitled to receive updates upon request if this office amends or changes its Notice of Privacy Procedures in a material way.

Parent/Guardian 1 Signature

Date

Parent/Guardian 2 Signature

Date

This section is to be completed by our office, if unable to obtain written acknowledgement from patient.

I made a good faith effort to obtain written acknowledgement of receipt of the Notice of Privacy Practices from the above-named patient, but was unable because:

Patient declined to sign this written acknowledgement.

Other (specify): _____

Name and title of employee

Date