PEAK Chiropractic

PEDIATRIC INTAKE

1684 Capitol Way
Bismarck, ND 58501
701-751-0642

PATIENT INFORMATION

Child's Name _____
Last Name

_____
First Name Middle Initial

Last 4 No's of SS# _____

Address _____

City/Town _____

State _____ Zip _____

Birth Date _____

Sex ☐ M ☐ F Age _____

Birth Weight _____

Current Weight _____

Birth Length _____

Current Length _____

No. of Siblings _____

IN CASE OF EMERGENCY, CONTACT

Mother's Name _____

Cell Phone (_____) _____

Work Phone (_____) _____

Father's Name _____

Cell Phone (_____) _____

Work Phone (_____) _____

PURPOSE OF APPOINTMENT

Purpose of this appointment _____

_____

_____

_____

PATIENT DETAILS

Pregnancy History _____ Birth History _____

Type of Birth: Normal Vaginal_____ Forceps_____ Breech_____ Cesarean_____

Home_____ Birthing Center_____ Hospital_____

Was there presence at birth of: _____Jaundice (Yellow) _____Cyanosis (Blue)

Congenital Anomalies/Defects _____

Infant Feeding: Breast_____ Bottle_____ Formula_____

No. of hours of sleep per night_____ Quality of Sleep: Good_____ Fair_____ Poor_____

Obstetrician/Midwife _____
Name Located at

Pediatrician/Family MD _____
Name Located at

Date of last visit to MD _____ Purpose _____

Immunization History Normal_____ Delayed_____ None_____

Has your child been treated on an emergency basis? _____

Describe _____

- OVER -

PEDIATRIC CASE HISTORY

Developmental History: At what age did the child...

Respond to Sound	_____	Crawl	_____	Sit alone	_____
Follow an object with his/her eyes	_____	Stand	_____		
Hold head up	_____	Walk alone	_____		

Has this child ever suffered from:

Dizziness	☐ Yes	☐ No	Backaches	☐ Yes	☐ No	Hypertension	☐ Yes	☐ No	Allergies	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No	Asthma	☐ Yes	☐ No	Constipation	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	Headaches	☐ Yes	☐ No	Sinus Trouble	☐ Yes	☐ No	Diarrhea	☐ Yes	☐ No
Neuritis	☐ Yes	☐ No	Digestive Disorders	☐ Yes	☐ No	Orthopedic Problems	☐ Yes	☐ No	Behavioral Problems	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No	Sugar Concentration	☐ Yes	☐ No	Muscle Jerking	☐ Yes	☐ No
Poor Appetite	☐ Yes	☐ No	Hyperactivity	☐ Yes	☐ No	Paralysis	☐ Yes	☐ No	Ruptures/Hernias	☐ Yes	☐ No
Bed Wetting	☐ Yes	☐ No	Convulsions	☐ Yes	☐ No	Broken Bones	☐ Yes	☐ No	"Growing Pains"	☐ Yes	☐ No
Fainting	☐ Yes	☐ No	Walking Problems	☐ Yes	☐ No	Leg Problems	☐ Yes	☐ No	Other _____		
Neck Problems	☐ Yes	☐ No	Arm Problems	☐ Yes	☐ No	Chronic Earaches	☐ Yes	☐ No	_____		
Joint Problems	☐ Yes	☐ No	Heart Trouble	☐ Yes	☐ No	Colds/Flu	☐ Yes	☐ No	_____		

Accidents/Injuries _____

_____

_____

Surgeries _____

_____

_____

MEDICATIONS

_____
_____
_____
_____
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_____
_____

SPORTS/ACTIVITIES

_____
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FAMILY HEALTH HISTORY

_____
_____
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_____
_____

AUTHORIZATION FOR CARE OF MINOR

I hereby authorize PEAK Chiropractic and it's doctor(s) to provide care as they so deem necessary to my son/daughter/ward.

Parent/Guardian (Print) _____ Relation _____ Date _____

Parent/Guardian Signature _____

PEAK Chiropractic

Informed Consent

To the Patient: Please read document and sign. It is important that you understand the information contained in this document:

The nature of the chiropractic adjustment: The primary treatment used by doctors of chiropractic is spinal manipulative therapy. The doctor will use that procedure to treat you. She may use her hands or mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click" much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis/Examination/Treatment: As part of the analysis, examination and treatment, you are consenting to the following procedures: spinal manipulative therapy, palpitation, trigger point massage, range of motion testing, orthopedic testing, neurological testing, muscle strength testing, postural analysis testing, ultrasound, cold therapy, biofreeze application, electric muscle therapy, and traction therapy.

The risks inherent in chiropractic adjustment: As with any other healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy such as fractures or minor muscle pulls. It is common to feel stiffness or soreness following the first few days of treatment. Fractures are rare occurrences and generally result from some underlying weakness of the bone. Stroke or vertebral artery dissection caused by chiropractic manipulation of the neck has not been officially proven but continues to be anecdotal. The doctor will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would not come to the doctor's obvious attention, it is your responsibility to inform the doctor.

Authorization for the release of patient information: I hereby authorize PEAK Chiropractic to provide other health care providers with information regarding my healthcare as deemed appropriate, give my permission for the use of medical records, including x-rays and information shared during the process of examinations and treatment to be released to insurance companies, other doctors, health consultants and or staff involved in my care.

Do not sign until you have read and understand the above.

I have read or have had read to me the above explanation of the chiropractic adjustment and related treatment. I have had all my questions answered to my satisfaction. By signing below, I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to under the treatment recommended. I hereby give my consent to chiropractic treatment and authorize any pertinent medical records exchange. I understand the consent to be effective until I am notified otherwise.

Patient's Signature:_____

Signature of parent/guardian (if minor) _____

Date:_____

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PEAK Chiropractic

No Cancellation / No Show Policy

Here at PEAK Chiropractic, we strive to provide you with the very best care and attention that we can. Our patients are very important to us and we want to provide the highest standard of care possible.

We understand that unanticipated events occur in everyone's lives. However, out of respect for our practitioner and other patients, we ask that you try your best to be on time for scheduled appointments. We ask for a **minimum of 2 hour** notice if you are unable to make your scheduled appointment.

We are implementing a "No Cancellation / No Show" policy that is effective immediately.

No Cancellation / No Show Policy

If a patient does not show for a scheduled appointment and does not provide a cancellation notice at least two hours prior to the appointment, the patient will be accessed a $25.00 fee. Emergency situations will be handled on a case by case basis.

We have patients that are on a waiting list for any daily appointments that open up. When appointments are not canceled in a timely matter, we are not able to assist those patients on the wait list.

Appointment Reminders

To assist our patients in this policy implementation, we are subscribing to a service that will send out both e-mail reminders and text message reminders **24 hours prior** to your scheduled appointment. Please respond to the text messages as to your appointment confirmation.

With this implementation, we want to make sure we have the best e-mail address and cell phone number on file for you. Please provide that below.

E-Mail: _____

Cell Phone No. (for text messages): _____

I, the undersigned, have been informed about PEAK Chiropractic's No cancellation / No show policy.

PATIENT NAME: _____ DATE: _____