AMBERWOOD TERRACE CHIROPRACTIC

663 CR 17, Suite 3
Elkhart, IN 46516
574-522-2255

# PATIENT INTAKE FORM - INFANT/CHILD

| | | |
|---|---|---|
| | Todays Date: / / | Birthdate: / / Age: |
| Name: | | Circle: Male / Female |
| Address: | City: | State: Zip: |
| Emergency Contact: | Relationship: | Phone #: |
| We are in-network with Anthem Blue Cross Blue Shield / Sagamore / Medicare - is the child covered under one of these? Yes / No | | |
| If yes, please circle provider above | Insured Person's Name: | |
| Insured's DOB: | ID#: | Group#: |

## CURRENT HEALTH CONDITION

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| Chief Compliant: (Why is the child here today?) |
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| When did the symptoms start? |
| What may have caused the onset? ☐ Fall ☐ Over Exertion ☐ Repetitive Motion ☐ Slept Wrong ☐ Unknown |
| What helps relieve the symptoms? ☐ Activity ☐ Cold ☐ Heat ☐ Massage ☐ Stretching ☐ OTC Meds ☐ Nothing |

## REVIEW OF SYMPTOMS

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| **EARS, NOSE AND THROAT** (Please circle all that apply): Bleeding / Discharge / Dizziness / Snoring / Fainting / Headaches<br>Loss of smell / Frequent sore throat / Nasal congestion / Sinus infections / Ear Drainage / Ear Infections / Hearing loss / Ear Pain /<br>Ringing in ears / Post nasal drip / Difficulty swallowing / Hoarseness / Runny nose / TMJ problems / NO symptoms |
| **RESPIRATION** (Please circle all that apply): Asthma / Cough / Sputum production / Coughing up blood / Wheezing<br>Shortness of breath / NO symptoms |
| **GASTROINTESTINAL** (Please circle all that apply): Abdominal pain / Belching / Black tarry stools / Constipation<br>Diarrhea / Difficulty swallowing / Heartburn / Hemorrhoids / Indigestion / Jaundice (yellowing of skin) / Nausea / Vomiting<br>Rectal bleeding / Abnormal stool quality / Abnormal stool color / Abnormal stool consistency / NO symptoms |

## HEALTH HISTORY

**Birth Details** (Please circle): Uncomplicated vaginal birth / Complicated vaginal birth / Vaginal birth w/forceps / C-Section

**Infancy Feeding Details** (Please circle): Breast fed / Formula fed / Combination of the two

**Has the child been admitted to the hospital since birth?** Yes / No

If yes, please explain reason:

**Has the child undergone any surgeries?** Yes / No

If yes, please explain reason:

**Has the child sustained any significant injuries since birth?** Yes / No

If yes, please explain circumstance of injury:

**Has the child been immunized?** Yes / No

If yes, please circle: Dtap / Flu / Hepatitis A / Hepatitis B / Influenza / Polio (IPV) / MMR (Measles, Mumps & Rubella)

Pneumococcal / PPD (Mantoux test - TB) / Small Pox / TB / Varivax (Chicken Pox) / Whooping Cough (Pertussis)

**Has the child ever been treated by a Chiropractor?** Yes / No If yes, who?

How did the child respond to treatment?

**Has the child seen other doctors for this condition?** Yes / No If yes, who?

**Is the child currently taking any prescription medications?** Yes / No

If yes, please provide name of drug, dosage and frequency:

**Does the child have a history of antibiotic or prescription drug use?** Yes / No

If yes, please provide name of drug, dosage and duration of use:

**PLEASE READ CAREFULLY AND SIGN BELOW:**

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Amberwood Terrace Chiropractic (ATC) will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to ATC will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate care or treatment, any fees for services rendered will be immediately due and payable. I hereby authorize the Doctor to treat my child's condition as he or she deems appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed. It is understood and agreed that x-rays are for examination only and the x-ray negative will remain the property of ATC, being on file where they may be seen at any time while a patient of this office. I also agree that I am responsible for all bills incurred. I acknowledge that I have received ATC's Notice of Privacy Practices for protected health information.

Parent or Guardian's Signature: _____ Date: _____