NEW PATIENT INTAKE

Chiropractic [ages 0-17]

Account #: _____

Thank you for choosing Bountiful Life Chiropractic Center. We are committed to providing you and your family the highest quality of chiropractic care so you may enjoy an active and healthy lifestyle. Prior to your consultation, please complete the following paperwork as thoroughly as possible in order for us to gain a clear understanding of your health goals.
We will require a photocopy of your ***driver's license*** *(or government identification) for our records.*
We comply with all federal privacy standards. As such, all information you provide is confidential.

Is your child on Medicaid? If yes, please provide your card to our front desk staff member.

Child's Legal Name: _____

Date of Birth: _____ Age: _____ Nickname / Name child goes by: _____

Gender: ☐ Male ☐ Female

Parent/Guardian's Name: _____

Primary Phone #: (_____)_____-_____ ☐ Cell ☐ Home

Secondary Phone #: (_____)_____-_____ ☐ Cell ☐ Home

By providing us with a cell number, you will automatically be enrolled in ***text appointment reminders****.*

Email:_____

Email appointment reminders *in addition* to text reminders? ☐ Yes ☐ No

Preferred method(s) of communication: ☐ Phone Call ☐ Text ☐ Email

Address: _____ City, State: _____ Zip: _____

Emergency Contact Name (if other than parent): _____ Phone #: (_____)_____-_____

How did you hear about our clinic? (check all that apply)

☐ Google Search ☐ Facebook ☐ Instagram ☐ Referral from: (name) _____

(we will thank them with a special gift!)

☐ Driving by ☐ Other (please describe): _____

Has your child seen a chiropractor before? ☐ Yes ☐ No If yes, when? _____

Is your child receiving care from other health professionals? ☐ Yes ☐ No

If yes, what is the specialty or reason? _____

Who is your child's primary care physician? _____

SYMPTOM SURVEY

Please mark each applicable symptom with a 1 or 2

1 – Currently experiencing (in the last 6-8 weeks) | 2 – Have experienced in the past

GENERAL

___ Autism
___ Abuse/neglect
___ Chills
___ Chicken Pox
___ Colic
___ Convulsions
___ Dizziness/loss of balance
___ Fainting
___ Fever
___ Headaches/migraines
___ Insomnia
___ Weight loss/gain
___ Nerve pain
___ Hyperactivity
___ Nervousness/anxiety
___ Depression
___ Numbness
___ Sweats
___ Tremors
___ Night terrors/ sleepwalking
___ Cancer
___ Diabetes - type 1 or type 2?
___ Seizures
___ Dyslexia

EYES

___ Corrective lenses or contacts
___ Far sighted
___ Near sighted
___ Cataracts
___ Blind spots
___ Sensitivity to light
___ Eye pain

EARS, NOSE, & THROAT

___ Allergies
___ Colds
___ Deafness
___ Hearing loss
___ Ear aches
___ Ear discharge
___ Ear ringing (tinnitus)
___ Enlarged glands
___ Enlarged thyroid
___ Dental decay
___ Gum trouble
___ Loss of taste
___ Hoarseness
___ Nose bleeds
___ Sore throats
___ Sinus infections
___ Nasal obstruction
___ Loss of smell
___ Tonsillitis

MUSCULOSKELETAL

___ Difficulty crawling/walking
___ Arthritis
___ Bursitis
___ Hernia
___ Low back pain
___ Mid back pain
___ Neck pain/stiffness
___ Arm pain
___ Shoulder pain
___ Leg pain
___ Knee pain
___ Foot pain
___ Muscle cramps
___ Fractures
___ Sciatica
___ Spinal curvature

GENITO-URINARY

___ Bed wetting
___ Blood in urine
___ Frequent urination
___ Inability to control bladder
___ Kidney infection
___ Kidney stones
___ Painful urination
___ Pus in urine

CARDIOVASCULAR

___ High blood pressure
___ Low blood pressure
___ Heart condition
___ Pain over heart
___ Rapid heart rate
___ Slow heart rate
___ Poor circulation
___ Cold extremities (hands/feet)
___ Bruise easily
___ Swelling of ankles

RESPIRATORY

___ Asthma
___ Bronchitis
___ Chest pain
___ Chronic cough
___ Croup
___ Difficulty breathing
___ Spitting up blood
___ Spitting up phlegm
___ Wheezing

GASTROINTESTINAL

___ Belching or gas
___ Abdominal pain
___ Constipation
___ Diarrhea
___ Difficult digestion
___ Poor appetite
___ Ulcers
___ Vomiting
___ Vomiting blood
___ Abdominal bloating
___ Excessive hunger
___ Heartburn/reflux
___ Hemorrhoids
___ Jaundice/liver issues
___ Nausea
___ Gallbladder issues
___ Colitis
___ Irritable bowel syndrome

FEMALES ONLY

___ Painful menstruation
___ Menstrual cramps
___ Hot flashes
___ Irregular cycle
___ Lumps in breast(s)
___ Vaginal discharge
___ Nipple discharge

MALES ONLY

___ Prostate problems
___ Erectile dysfunction
___ Hesitancy/dribbling

Please check all that apply regarding your child/teen's birth:

☐ Natural vaginal (no medications/interventions)

☐ Vaginal with interventions ☐ *Induced* ☐ *Pain medications* ☐ *Epidural* ☐ *Foreceps* ☐ *Vacuum extraction*

Additional notes: _____

☐ C-section ☐ *Scheduled* ☐ *Emergency*

☐ Premature birth at _____ weeks

Surgeries (with approx. dates): _____

_____

Illnesses (with approx. dates): _____

_____

Accidents, Falls, Traumas, Fractures/broken bones (with approx. dates): _____

_____

Has your child had a concussion? ☐ Never ☐ One time ☐ Multiple times ☐ I think so, but not sure

Does your child drink caffeinated beverages? ☐ Never ☐ Occasionally ☐ Regularly

Has your child ever been prescribed antibiotics? ☐ Never ☐ One time ☐ Multiple times

If so, what for? _____

Please list current medications: _____

_____

Please list current vitamins or supplements: _____

_____

Allergic to any medications? ☐ Yes ☐ No If yes, which ones? _____

Allergic to any foods? ☐ Yes ☐ No If yes, which ones? _____

_____

Any environmental allergies? ☐ Yes ☐ No If yes, to what? _____

Any milestones your child has had difficulty with? ☐ Yes ☐ No If yes, please explain: _____

_____

What condition(s) lead you to seek chiropractic care? _____

_____

When did you first notice it? _____

What were they doing when you first noticed it? _____

_____

Have they had this condition / these symptoms before? ☐ Yes ☐ No If yes, when? _____

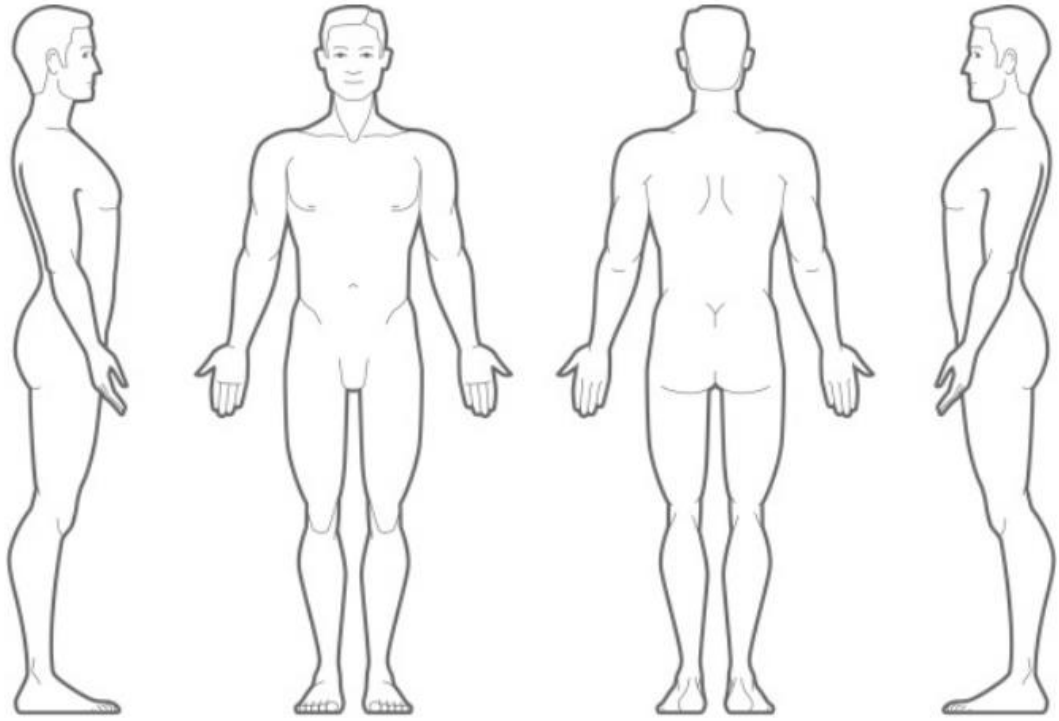
Do the symptoms radiate or travel to another area? ☐ Yes ☐ No ☐ Not sure

If yes, please describe: _____

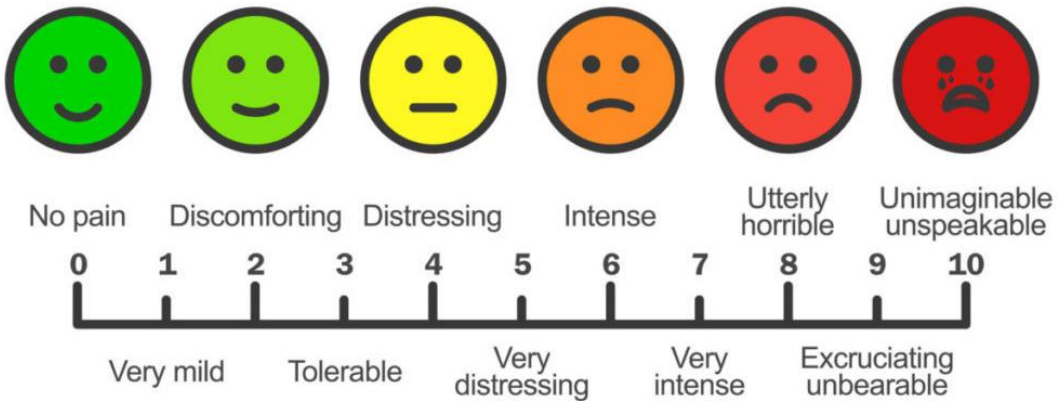
How frequently do they experience symptoms? (circle one)

Intermittently	Occasionally	Frequently	Constantly
[0-25% of day]	[26-50% of day]	[51-75% of day]	[76-100% of day]

Place an "X" on the diagram below in the locations you are experiencing symptoms:



How would you rate the intensity of the pain? (circle a number)



Is the pain (circle all that apply): Sharp Dull Aching Burning Numb Throbbing Pins & Needles

What makes symptoms better? _____

What makes symptoms worse? _____

What movements/activities are difficult? _____

TERMS OF ACCEPTANCE

Chiropractic has only one goal - to serve the health needs of you, the patient. When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral or extremity subluxation. Our chiropractic method of correction is by specific adjustments of the spine, as well as extremities.

Health: A state of optimal physical, mental and social well-being, not merely the absence of infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebrae in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

Extremity Subluxation: A misalignment of an extremity causing edema, fixation and or joint irregularity. The aim of extremity adjusting is to assess the extremity, then do an analysis, and then develop a treatment for the extremity and synchronize this plan with the plan for the spinal treatment.

We may diagnose any condition or disease that comes into our office in addition to the vertebral and extremity subluxations. It is our goal to refer a patient to their health care practitioner, or in urgent matters, to the closest emergency room if we feel their health, or our diagnosis, warrants the referral.

We do not treat diseases or conditions in our office beyond the spine or extremities, however, other diseases may improve with chiropractic care. In doing so, it's important to work with you, the patient, on reaching your optimal health. Our only practice objective is to serve you the patient.

PATIENT HEALTH INFORMATION CONSENT FORM

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 operations, 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.

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 affect 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.

If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, our office has the right to refuse to give care.

CONSENT TO CARE FOR MINOR

I authorize Dr. LaBounty & Dr. Miller to administer care as they so deem necessary to my minor dependent.

X-RAY RELEASE

This is to certify that Dr. LaBounty & Dr. Miller have my permission to perform an X-ray evaluation.

Females: To the best of my knowledge, my dependent minor is not pregnant and I understand that x-ray can be hazardous to an unborn child.

Date of last menstrual cycle: _____

PAYMENT / INSURANCE

I understand that Bountiful Life Chiropractic Center will provide a receipt to assist me in making collection from any insurance company. I clearly understand that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend my care and treatment, any fees for professional services rendered me will be immediately due and payable.

I have read and understand the above and I agree to these policies and procedures. All questions about this page have been answered to my satisfaction and I therefore accept care at Bountiful Life Chiropractic Center on this basis.

Signature of Patient's Legal Guardian: _____

Guardian's Printed Name: _____ Date: _____