DUNN CHIROPRACTIC

Children Intake Paper Work

Today's Date: ____/____/_____

Patient Information:

First Name:_____(Preferred Name:_____) MI:_____ Last Name:_____

Address:_____

City:_____ State:_____ Zip Code:_____

Primary Phone: (_____)_____-_____ [ ] Home [ ] Work [ ] Cell

Birthday: _____/_____/_____ Parents Name:_____

Gender: [ ] Male [ ] Female

Health Profile

If your child has no symptoms or complaints, and is here for wellness services, please check [ ]. If not, please briefly describe the chief area of complaint.

_____

_____.

1. Who is your child's current Medical Doctor? Name:_____Phone: (_____)_____-_____
2. When did your child's current complaints begin (approximately)?

   _____
3. If she/he is experiencing pain, is it: [ ] Sharp [ ] Dull [ ] Comes & Goes [ ] Constant
4. Does it interfere with any daily activities (school, sleep, walking, sitting, playing etc.)? [ ] Yes [ ] No

   If yes, please explain: _____
5. Has your child been hospitalized? [ ] Yes [ ] No

   If yes, please list dates and reasons below:

Date(s)	*Hospital Name & Location*	*Reason*

6. List any broken bones or fractures they have suffered:_____
7. Does your child suffer from any other medical conditions we should be aware of? [ ] Yes [ ] No

   If yes, please list:_____
8. Are they presently taking any prescription medication/supplements? [ ] Yes [ ] No

   If yes, please list: _____

Prenatal History:

1. Complications during pregnancy? YES NO If yes, list:_____
2. Complications during delivery? YES NO If yes, list:_____
3. Birth Intervention: FORCEPS Vacuum Extraction
   C-SECTION—EMERGENCY or PLANNED?

Childhood Years:

1. Has your child fallen from a height over 3 ft.? YES NO If yes, list:_____
2. Is/has your child been involved with high impact sports or contact sports (soccer, football, gymnastics, baseball, martial arts, etc.)? YES NO If yes, list:_____
3. Has your child ever been in a car accident? YES NO If yes, list:_____
4. Others traumas not described above? YES NO If yes, list:_____

*Please give us any other health information that you feel would be helpful:

_____

_____.

Informed Consent

PLEASE READ AND SIGN BELOW:

I hereby authorize this office to examine and treat my child's condition as they deem appropriate through the use of Chiropractic Health Care. I understand that I may obtain copies of my child's medical file upon request, and that copying fees may apply for these records.

I have had an opportunity to discuss with the Doctor and/or with other office or clinic personnel the nature and purpose of Chiropractic adjustments and other procedures. I understand and am informed that, as in the practice of Medicine, in the practice of Chiropractic there are some risks to treatment including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. It is not reasonable to expect the Doctor to be able to anticipate and explain all risks and complications of a given procedure on any particular visit, 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 child's best interests.

Chiropractic treatment involves the Science, Philosophy and art of locating and correcting spinal misalignments and as such, is oriented toward improvement of spinal function relative to range of motion, muscular and neurological aspects. There has been no promise, implied or otherwise, of a cure for any symptoms, disease or condition as a result of treatment in this clinic. I understand that the Chiropractor will use his hands or a mechanical device upon my child's body to adjust a joint, which may cause an audible "pop" or "click." It is my intention to rely on the Doctor to exercise professional judgment during the course of any procedures, which he feels at the time to be in my child's best interest. Neither the practice of Chiropractic or Medicine is an exact Science, but relies upon information related by the patient, information gathered during examination, and the Doctor's interpretation thereof, as well as the Doctor's judgment and expertise in working with like cases.

In addition, my signature below acknowledges my Patient Consent for Use and Disclosure of Protected Health Information and I have had an opportunity to ask questions.

Patient's **Printed** Name:_____

Patient's (or Parent/Legal Guardian's) **Signature**:_____Dated:_____/_____/_____

*Assistant's Signature:*_____ Dated:_____/_____/_____

*Doctor's Signature:*_____ Dated: _____/_____/_____

Billing Statement and Policy for Dunn Chiropractic

Payment is expected in full at the time of service unless financial arrangements have been made with the office manager or doctor prior to having an adjustment.

Insurance (out of network)

We will file insurance for you, however, the insurance company will pay you directly once the deductible has been met and the visit limit or annual maximum has not been exceeded which is based on your chiropractic insurance coverage. You will still be expected to pay in full for all charges at the time of service. We will only be paid directly by insurance companies under the following conditions; car accident, workman's compensation, and Medicare with supplement insurance.

Anthem-BCBS

Dunn Chiropractic is considered an in-network provider for BCBS. Your benefits/eligibility, coverage, and copayments are based on your chiropractic insurance policy. If your insurance denies any charges you will be responsible for those bills not covered. You are expected to pay copayments at the time of service. As a service, we will check on your coverage for you.

Medicare Insurance

Medicare insurance will be submitted on a participating basis. We do accept assignment. This means we will send all claims to Medicare unless specified by patient. If Medicare denies any services, you will be responsible for those bills not covered by Medicare or Supplemental Insurance. Some charges that are NOT covered by Medicare are: x-rays, extremity adjustments (legs-arms), examinations, all therapies, vitamins, braces, etc.

I have read and understand the above statement for the billing policy of Dunn Chiropractic.

_____

Signature

_____

Date

THIS PAGE IS FOR OFFICE USE ONLY:

Blood Pressure:

_____/_____ Measured: Standing/Sitting Using: Right/Left Arm/Leg_____

_____/_____ Measured: Standing/Sitting Using: Right/Left Arm/Leg_____

Height: _____Ft. _____In. **Weight:** _____lbs. **George's Test:** Negative _____ Positive (signs)_____

Demeanor:

Alert/Oriented Agitated Distressed Guarded Obesity Requires Assistance_____

Rate your pain in each area using the following scale. (You may select a range as in the example.)

NO PAIN — MODERATE PAIN — MOST SEVERE PAIN

	0 1 2 3 4 5 6 7 8 9 10
EXAMPLE	0 1 (2) 3 4 (5) 6 7 8 9 10
Headaches	0 1 2 3 4 5 6 7 8 9 10
Neck	0 1 2 3 4 5 6 7 8 9 10
Upper Back	0 1 2 3 4 5 6 7 8 9 10
Mid-Back	0 1 2 3 4 5 6 7 8 9 10
Lower Back	0 1 2 3 4 5 6 7 8 9 10
Pelvis	0 1 2 3 4 5 6 7 8 9 10
Other	0 1 2 3 4 5 6 7 8 9 10

How often do you experience pain?

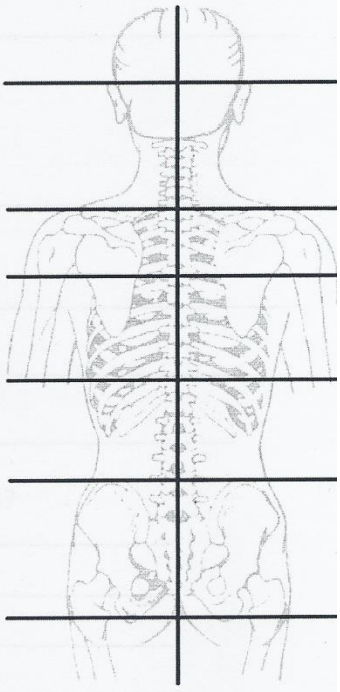
Constant (100%-76%) | Frequent (75%-51%) | Occasional (50%-26%) | Intermittent (25%-0%)

Describe the type of pain you are experiencing.

Dull Ache | Tightness | Tingling | Shooting | Numbness | Burning | Sharpness | Discomfort | Other- Describe_____

Mark the area(s) that you are experiencing pain using a circle or X.

Left Right



Specify the Area:_____

Other Notes:

_____

_____

_____

History/Exam Reviewed By: _____Date:_____/___/_____