Patient Name: _____

Pediatric New Patient Intake Form

Informed Consent | Financial Policy | Privacy Policy

Date_____

☐CWP_____ ☐PI ☐WC ☐VA ☐MEDICARE ☐INS

Parent's Full Name_____

Child's Full Name_____ **Date of Birth** _____ **Sex** □ Male □ Female

Address_____ **City**_____ **State**_____ **Zip** _____

Cell Phone _____ **Home Phone** _____ **E-mail**_____

Family Doctor / Pediatrician _____ **Clinic Name** _____

Preferred method of communication. □ Cell Phone □ Home Phone □ E-mail □ Other _____

Your Marital Status □ M □ S □ W □ D **Name of Spouse/Significant Other**_____ **Phone** _____

Emergency Contact _____ **Relationship** _____ **Phone** _____

How did you hear about us? _____

CONSENT TO CHIROPRACTIC EXAMINATION AND TREATMENT

To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in it. Please ask questions if there is anything that is unclear before you sign.

Information about the Chiropractic Adjustment
The primary treatment used in the clinic is spinal manipulative therapy or the chiropractic adjustment. It is likely that spinal manipulative therapy will be used as part of your treatment. Spinal manipulative therapy includes placement of the doctor's hands or mechanical instruments upon your body in such a way as to mobilize your joints. This movement may cause an audible "pop" or "click," such as experienced when you "crack" your knuckles. You may also feel a sense of movement.

The Material Risks Inherent in the Chiropractic Adjustment
All patient care, including chiropractic treatment, has the potential for negative effects. The risks associated with chiropractic treatments include, but are not limited to, dislocations and sprains, disc injuries, fractures, and strokes. These negative effects are very rare but nevertheless exist. The Doctors at JayMac Chiropractic will develop a treatment plan recommending what they feel is in your best interest based on clinical examination, patient history, and professional experience.

The Probability of Those Risks Occurring
Fractures are rare occurrences and generally result from some underlying weakness of the bone which your doctor looks for during your initial consultation, examination, and while reviewing your x-rays if indicated or recommended. Stroke has been the subject of tremendous disagreement. The incidence of a stroke is exceedingly rare and is estimated to occur between one in one million and one in five million adjustments of the neck. The other complications are also generally described as rare.

The Availability and Nature of Other Treatment Options
Other treatment options for your condition may include: Self-administered, over-the-counter analgesics, Rest, Medical care, Prescription medications such as anti-inflammatory, muscle relaxants and pain-killers, Hospitalization, and Surgery. If you choose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary care physician.

Overuse of over-the-counter medications produces undesirable side effects. If complete rest is impractical, premature return to work and household chores may aggravate the condition and extend the recovery time. The probability of such complications arising is dependent upon the patient's overall health, severity of discomfort, their pain tolerance, and their self-discipline in not abusing the medication. Professional literature describes highly undesirable effects from long term use of over-the-counter medications.

Prescription muscle relaxants and pain killers can produce undesirable side effects and patient dependence. The risk of such complications arising is dependent upon the patient's overall health, severity of discomfort, their pain tolerance, their self-

discipline in not abusing the medication, and proper professional supervision. Such medications generally entail very significant risks – some with rather high probabilities.

Hospitalization in conjunction with other care, bears the additional risk of exposure to communicable diseases, iatrogenic (doctor induced) mishap and expense. The probability of iatrogenic mishap is remote, expense is certain; exposure to communicable disease is likely with adverse results from such exposure being dependent upon many variables.

The risks inherent with surgery include adverse reaction to anesthesia, iatrogenic (doctor induced) mishap, all risks associated with hospitalization, and an extended convalescent period. The probability of those risks occurring varies to many factors.

The Risks and Dangers Attendant to Remaining Untreated
Remaining untreated may allow the formation of adhesions and reduce mobility of your joints which may set up a pain reaction further reducing mobility and overall range of motion. Over time this process may compromise your recovery making treatment more difficult and less effective the longer it is postponed. The probability that non-treatment will complicate a later rehabilitation is very high.

The Chiropractic Examination
Prior to establishing a treatment plan, the doctor must perform a Chiropractic Examination in order to determine the probable cause of your complaint. During the examination the doctor will perform some procedures or maneuvers intended to reproduce your symptoms which will allow for a better understanding of the nature of your condition and for the development of an appropriate treatment regimen. There is a slight possibility that these maneuvers may temporarily aggravate your symptoms.

Documented Patient Noncompliance
Every effort will be made to help you achieve maximum health. It is important to keep your appointments and follow through with the prescribed treatment plan. We understand busy schedules and anticipate these as a part of life, however, please be courteous and inform us of any conflicts in scheduling immediately so that we may accommodate you accordingly and schedule other patients in need. If the noncompliance reaches the point of jeopardizing "good quality care," we may formally discharge you as a patient with an appropriate letter of withdrawal. Your patient records will note such problems of noncompliance and you will be provided an alternative source of recovery.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE

I have read or have had read to me the above explanations regarding the chiropractic examination, adjustment, and related treatment and have discussed it with the Doctors at JayMac Chiropractic and have had my questions answered to my satisfaction.

By signing below I state that I understand the benefits, risks, and alternatives involved in undergoing treatment and have decided that it is in my best interest or my child's best interest to undergo the treatment recommended by the Doctors at JayMac Chiropractic. Having been informed of the benefits, risks, and alternatives, I hereby give my consent to the prescribed and recommended treatment. I intend this consent to cover any examinations and treatments for my present condition and for any future conditions for which I seek treatment from JayMac Chiropractic.

If the patient is a minor, I hereby authorize the doctors and staff at JayMac Chiropractic to examine my child and to treat his/her condition as deemed appropriate, which may or may not include diagnostic imaging.

Date _____ Date _____

_____ _____

Printed Name of Patient *or* Parent/Guardian (if a minor) Signature of Doctor

_____

Signature of Patient *or* Parent/Guardian (if a minor)

ACKNOWLEDGMENT OF FINANCIAL RESPONSIBILITY

I acknowledge and accept the following:

Health and accident insurance policies are an arrangement between an insurance carrier and me. JayMac Chiropractic will help prepare and submit claim forms and necessary medical records to assist me in making collection from the insurance company.

JayMac Chiropractic **CAN NOT** guarantee that my insurance company will pay. Prior to or immediately after my first visit, JayMac Chiropractic will make every attempt to receive and verify benefits and coverage. I understand that if I seek treatment outside of JayMac Chiropractic, my remaining benefits may not be accurate and claims may be denied due to exhausted benefits. I understand that insurance claims may be denied if I see multiple providers for the same injury or complaint.

I hereby assign all medical and chiropractic benefits to which I am entitled to JayMac Chiropractic. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other medical plan or representative to issue payment check(s) or direct deposits directly to JayMac Chiropractic for medical or chiropractic services rendered to myself and/or my dependents.

All services rendered to me are charged directly to me and that I am personally responsible for payment. I understand that I am responsible for any amount not covered by insurance. I also understand that if I suspend or terminate my care and treatment or insurance policy, any fees for professional services rendered to me will be immediately due and payable.

*Effective October 1, 2022, all patients will be required to have a credit card on file (CCOF) regardless of insurance or visit type. Personal injury and worker's compensation patients wi not be required to provide a CCOF until after discharge and continuation of care. See CCOI Policy online at *http://www.JayMacChiropractic.com/CCOF.html* for additional details.

Scan to view CCOF Policy

*A **Medical Lien** will be filed in Maricopa County, Arizona on behalf of JayMac Chiropractic for all ongoing medical expenses accrued in the office and with all involved 3rd party payers and legal representatives, regardless of fault, for all Personal Injury cases to ensure that all my treatments and visits are covered by the appropriate entity. A copy of the lien will be provided when filed. I acknowledge that any changes to this process must be discussed and agreed upon within 30 days. Please seek legal counsel relative to this financial policy.

_____ _____ _____

Printed Name of Patient *or* Parent/Guardian (if a minor) | Signature of Patient *or* Parent/Guardian (if a minor) | Date

ACKNOWLEDGEMENT OF REVIEW OF PRIVACY PRACTICES

I have reviewed JayMac Chiropractic's Notice of Privacy Practices, located at *http://www.JayMacChiropractic.com/privacy.html*.

This policy explains how my Protected Health Information (PHI) will be used and disclosed. I have had my questions satisfactorily answered considering this policy. I understand that I may request a physical or digital copy of this document upon request at any time.

Scan to view Privacy Policy

_____ _____ _____

Printed Name of Patient *or* Parent/Guardian (if a minor) | Signature of Patient *or* Parent/Guardian (if a minor) | Date

---------- **FOR OFFICE USE ONLY**----------

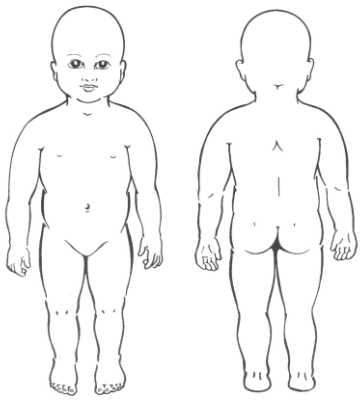
JayMac Chiropractic attempted to obtain written acknowledgment of receipt or review of our Notice of Privacy Practices, but acknowledgment could not be obtained because (please specify) _____

_____

Staff Signature _____ Date _____

Patient Name: _____

List and describe your child's major complaints	How long?	Rate their pain
		0 1 2 3 4 5 6 7 8 9 10
		0 1 2 3 4 5 6 7 8 9 10
		0 1 2 3 4 5 6 7 8 9 10
		0 1 2 3 4 5 6 7 8 9 10
		0 1 2 3 4 5 6 7 8 9 10
		0 1 2 3 4 5 6 7 8 9 10



Has your child been treated yet? □ Y □ N Explain:

What makes their condition BETTER?

What makes their condition WORSE?

Does the pain/numbness RADIATE? □ Y □ N Explain:

What time of day is their condition BETTER? **What time of day is their condition WORSE?** □ **Same all day**

Does their condition interfere with any of the following: □ School □ Sleep □ Recreation □ Social life □ Family life

Has your child had this condition in the past? □ Y □ N Explain:

Date of last Chiropractic treatment? **Name of previous chiropractor?**

CHILD'S MEDICAL HISTORY: Describe any of the following. Provide approximate dates. □ PD

Infections: _____ Major Trauma: _____

Hospitalizations: _____ Spinal or neck injuries: _____

Automobile/Motorcycle accidents: _____ Falls or other injuries: _____

Other injuries: _____ All Recommended Vaccinations: □ Y □ N

Surgeries: _____

Allergies? □ Y □ N Explain _____

FAMILY MEDICAL HISTORY: Describe any medical issues in your family. Provide approximate dates. □ Adopted/Unknown □ PD

Mother: _____ Father: _____

Sister(s): _____ Brother(s): _____

Maternal Grandmother: _____ Paternal Grandmother: _____

Maternal Grandfather: _____ Paternal Grandfather: _____

LIST ALL CHILD'S MEDICATIONS and NUTRITIONAL SUPPLEMENTS **REASON FOR TAKING** □ PD

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Drug Allergies/Interactions? □ Y □ N Explain _____

Patient Name: _____

CHILD'S SOCIAL HISTORY:

Tobacco Use: □ Child □ Household
Alcohol Use: □ Child □ Household
Drug Use □ Child □ Household
Caffeinated Drinks □ Child □ Household
Child's Daily Water Intake _____
Balanced Nutritional Meals □ Y □ N
Fast Food Meals □ Y □ N How often _____

Exercise ____ Hours/day
Sleep ____ Hours/day
Computer Use ____ Hours/day
TV/Video Games ____ Hours/day
Cell Phone Use ____ Hours/day

Rate Child's DIET 0 1 2 3 4 5 6 7 8 9 10
Rate Stress at HOME 0 1 2 3 4 5 6 7 8 9 10
Rate Stress at SCHOOL 0 1 2 3 4 5 6 7 8 9 10
Stress Outlets _____

Has your child been involved in any high impact/contact sports (football, soccer, martial arts, cheerleading, etc)? □ Y □ N

CHILD'S EMOTIONAL HEALTH:

Positive Self Esteem/Image □ Y □ N Explain:

Prolonged Sadness □ Y □ N Explain:

Difficulty interacting w/ others □ Y □ N Explain:

Nervous, Twitching, Shaking, or Rocking Behavior □ Y □ N Explain:

ANSWER THE FOLLOWING QUESTIONS IF YOUR CHILD IS UNDER 3

PRENATAL HISTORY:

Birth weight _____ **Birth Length** _____

Where did you give birth? □ Home □ Birthing center □ Hospital □ Other _____
Delivery Method? □ Vaginal □ Forceps □ Vacuum Extraction □ C-Section □ Other _____

What position was the baby in during delivery? □ Normal face down □ Breach □ Transverse □ Footling breach □ Other_____
Were you under chiropractic care during the pregnancy? □ Yes □ No
Were there any complications during the pregnancy or with the delivery? □ Yes □ No Explain _____

Are there any known congenital anomalies/defects? □ Yes □ No Explain _____

During pregnancy, did you use any of the following: □ Alcohol □ Tobacco products □ Medications □ Recreational Drugs □ None
During pregnancy, did you experience any illness or infection? □ Yes □ No Explain _____
During pregnancy, were you involved in any major falls, trauma, accidents, etc? □ Yes □ No Explain _____
Was Ultrasound used during pregnancy? □ Yes □ No How many times? _____

Do you breastfeed the baby? □ Yes □ No How long? _____
Any difficulties breastfeeding? □ Yes □ No Explain _____
Do you formula-feed the baby? □ Yes □ No How long? _____
At what age did you introduce: Solids _____ Cow's milk _____

Patient Name: _____

REVIEW OF SYSTEMS

Select the following conditions that apply to you.

Constitutional PD
□ Balance issues
□ Cancer
□ Changes in appetite
□ Changes in sleep
□ Changes in weight
□ Chills
□ Dizziness
□ Fatigue
□ Fever
□ Hyperactivity
□ Tumor
□ Vertigo

Cardiovascular PD
□ Angina/Chest pain
□ Atrial fibrillation (AFib)
□ DVT or Blood Clot
□ Embolism
□ Fainting
□ Hardening of arteries
□ Heart attack
□ Heart disease
□ High blood pressure
□ Low blood pressure
□ Poor circulation
□ Rapid heart beat
□ Slow heart beat
□ Stroke
□ Swollen ankles
□ Varicose veins

Respiratory PD
□ Asthma
□ Bronchitis
□ Chronic cough
□ COPD
□ Difficulty breathing
□ Emphysema
□ Shortness of breath
□ Sleep apnea □ CPAP

Gastrointestinal (GI) PD
□ Acid reflux
□ Belching or gas
□ Celiac Disease
□ Colon issues
□ Constipation
□ Crohn's Disease
□ Diarrhea
□ Gall bladder issues
□ Heartburn
□ Hemorrhoids
□ Hiatal hernia
□ Jaundice
□ Liver issues
□ Nausea
□ Spitting up blood
□ Stomach aches
□ Stomach ulcers
□ Vomiting

Genitourinary (GU) PD
□ Bed-wetting
□ Bladder infection
□ Blood in urine
□ Kidney infection
□ Kidney stone
□ Painful urination
□ Poor urine control
□ Urinary Tract Infection

Musculoskeletal PD
□ Arm pain
□ Arthritis
□ Broken bones
□ Bursitis
□ Elbow pain
□ Foot pain
□ Hip pain
□ Knee pain
□ Leg pain
□ Low backache
□ Muscle atrophy
□ Pain btwn shoulders
□ Painful tailbone
□ Plantar Fasciitis
□ Rib Pain
□ Scoliosis
□ Shoulder pain
□ Spinal curvature
□ Sprained ankle
□ Weakness in arms
□ Weakness in legs
□ Wrist pain

Integumentary/Skin PD
□ Bruise easily
□ Eczema/Hives
□ Hair/Nail Changes
□ Itching (Pruritis)
□ Moles (Irregular)
□ Psoriasis
□ Rashes
□ Scaling
□ Skin cancer

Neurological PD
□ Burning sensations
□ Convulsions
□ Numbness in arm/hand
□ Numbness in leg/foot
□ Pins/Needles/Tingling
□ Restless Leg Synd. (RLS)
□ Sciatica
□ Seizures

Psychiatric PD
□ ADHD/ADD
□ Anxiety
□ Dementia
□ Depression
□ Nervousness
□ Paranoia
□ PTSD
□ Stress/Tension

Endocrine PD
□ Diabetes Type: □ I □ II
□ Enlarged Glands
□ Frequent urination
□ Gout
□ Hypoglycemia
□ Swollen joints
□ Thyroid issues

Hematological/Lymphatic
□ Anemia PD
□ Blood disorder
□ HIV/AIDS

Allergy/Immunologic PD
□ Seasonal Allergies
□ Food Allergy/Intolerance
□ Rheumatic fever
□ Tuberculosis

EEMNT PD
□ Dental issues
□ Difficulty swallowing
□ Ear infection(s)
□ Hearing issues
□ Nasal congestion
□ Nosebleeds
□ Ringing in ears
□ Sinus infection
□ Sore throat
□ TMJ pain
□ Vision issues □ corrected

Head/Neck PD
□ Headaches
□ Migraines □ w/ Aura
□ Painful neck
□ Stiff neck

List any other conditions
_____
_____
_____
_____

For GIRLS Only PD

□ Breast lumps or pain
□ Irregular cycle
□ Irregular flow ↑ ↓
□ Menstrual cramps
□ Premenstrual tension
□ Vaginal discharge

Last Breast Exam: _____
Last Menstrual Period: _____

Regular Checkups? □ Yes □ No

For BOYS Only PD

□ Breast lumps or pain
□ Changes in bathroom habits
□ Testicular issues

Last Testicular Exam: _____

Regular Checkups? □ Yes □ No

PD = Patient Denied All Issues
CC = chief complaint
Circle current conditions

CONFIDENTIAL PROTECTED HEALTH INFORMATION (PHI)

I acknowledge that the health history and demographics above are complete and accurate, and that if any changes in my health or demographics occur, I will discuss these changes with the Doctors at JayMac Chiropractic.

_____ _____ _____ _____
Patient Signature *or* Parent/Guardian (if a minor) Date Signature of Doctor Date