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RESILIENCE
HEALTH CENTER

PEDIATRIC INTAKE FORM

HELLO AND WELCOME TO RESILIENCE HEALTH CENTER!

Who may we thank for referring you / how did you hear about us? _____

Has your child received chiropractic care in the past? ❑ No ❑ Yes, as an ❑ Infant ❑ Child ❑ Teen

From whom did your child receive chiropractic care? _____ ❑ N/A

Please fill out the following information completely and to the best of your ability. Remember to initial the bottom of each page.

PERSONAL INFORMATION

Child's Name: _____ Date of Birth: _____ Age: _____

Child's Preferred Name: _____ Gender: ❑ Male ❑ Female

Address: _____ City/State/Zip: _____

Guardian #1: _____ Relationship to Child: _____

Phone (❑Cell ❑Home ❑Work): _____ Email: _____

Guardian #2: _____ Relationship to Child: _____

Phone (❑Cell ❑Home ❑Work): _____ Email: _____

Who is responsible for the child's finances? What is the relationship between #1 and #2:

❑ Guardian #1 ❑ Guardian #2 ❑ Both ❑ Married ❑ Divorced ❑ Other: _____

Siblings (Name/Age): _____

Child's Hobbies: _____

PRENATAL, BIRTH, & INFANCY HISTORY

If your child is above the age of 5, skip to PERSONAL HEALTH HISTORY

Child's Birth Weight: ___lb ___oz **Name of** ❑ Doctor/ ❑ Midwife: _____

Birth Height: ___in **At how many weeks of pregnancy was your child born?** _____

List any drugs/medications that you took during pregnancy: ❑ N/A _____

List any complications, serious illness, or health emergency that you experienced during the birth or pregnancy:

❑ N/A _____

Select the delivery method of your child's birth: ❑ Vaginal ❑ C-Section ❑ VBAC

PERSONAL HEALTH HISTORY

Child's Current Weight: ___lbs Height: **Height:** ___ ft. ___ in.

Has your child received vaccines? ❑ No ❑ Yes

(if yes) ❑ On schedule ❑ On a delayed schedule

Does your child have any genetic disorders or disabilities? ❑ No ❑ Yes (If yes, *explain*): _____

_____

Indicate if your child has experienced any of the following: ❑ N/A

❑ Serious illnesses, operation, or health emergency

❑ Been unconscious due to an illness or injury

❑ Been in a motor vehicle accident

❑ Fractured a bone

Explain (include year(s)): _____

List any over-the-counter/prescription drugs that your child is currently taking: ❑ N/A _____

_____

Is your child exposed to secondhand smoke? ❑ Never ❑ In the Past ❑ Occasionally ❑ Daily

 PATIENT INITIALS _____

CHIEF COMPLAINT / HISTORY OF PRESENTING ILLNESS

What is the <u>MAIN</u> symptom/pain/reason you are seeking chiropractic care for your child?

PROBLEM/CONCERN #1: _____

- WHEN did this problem begin? _____ Is it constant or intermittent? _____
- Did you do something / did something happen that aggravated the problem? ❑ No ❑ Yes
  Explain: _____
- WHEN is the problem at its worst? ❑ Morning ❑ Mid-day ❑ Evening ❑ Other _____
- Does the problem RADIATE outward from a source? _____
- What RELIEVES the problem? _____
- What makes the problem WORSE? _____

Are there any <u>SECONDARY</u> health concerns you wish to bring to our attention? ❑ No ❑ Yes

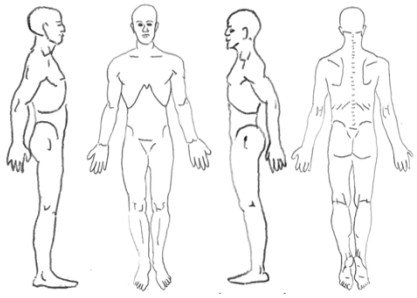
PROBLEM/CONCERN #2: ❑ N/A _____

- WHEN did this problem begin? _____ Is it constant or intermittent? _____
- Did you do something / did something happen that aggravated the problem? ❑ No ❑ Yes
  Explain: _____
- WHEN is the problem at its worst? ❑ Morning ❑ Mid-day ❑ Evening ❑ Other _____
- Does the problem RADIATE outward from a source? _____
- What RELIEVES the problem? _____
- What makes the problem WORSE? _____

DIRECTIONS: CIRCLE the area(s) on the diagram that relate to your child's pain/symptom(s)/issue(s):

How would you describe the problem(s)?

❑ Dull ache ❑ Burning ❑ Stiff/Tight
❑ Tingling ❑ Radiating ❑ Deep, boring
❑ Pounding ❑ Numb ❑ Sharp/Stabbing
❑ Other: _____



PAST HISTORY

Has your child's symptom/pain/reason for seeking chiropractic care happened before? ❑ Yes

- If yes, how many times? ❑ N/A _____ ❑ No
- What sort of treatment did you seek before? ❑ N/A _____
- What were the results of your previous treatment? ❑ N/A _____

Help us identify past conditions or procedures that could be <u>related to your child's main issue</u>:

❑ Past surgeries ❑ Childhood diseases ❑ Past injuries ❑ N/A *Explain*: _____

_____

Has your child experienced or been diagnosed with any of the following? ❑ N/A

❑ Pain that wakes you up at night ❑ Night Sweats ❑ Seizures ❑ Tumors ❑ Diabetes
Explain: _____

PATIENT INITIALS _____

QUADRUPLE VISUAL ANALOG SCALE

Child's Name: _____ **Date:** _____

PLEASE READ CAREFULLY

DIRECTIONS: Fill in your child's problem(s)/concern(s) from the previous page. *Regarding these problem(s)/concern(s)*, please CIRCLE the number that best describes the question being asked.

PROBLEM/CONCERN #1: _____

1. What is your pain RIGHT NOW?

No Pain _____ Worst Pain Possible

0 1 2 3 4 5 6 7 8 9 10

2. What is your TYPICAL or AVERAGE pain?

No Pain _____ Worst Pain Possible

0 1 2 3 4 5 6 7 8 9 10

3. What is your pain AT ITS BEST (How close to "0" does your pain get at its best)?

No Pain _____ Worst Pain Possible

0 1 2 3 4 5 6 7 8 9 10

4. What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?

No Pain _____ Worst Pain Possible

0 1 2 3 4 5 6 7 8 9 10

PROBLEM/CONCERN #2: ❑ N/A _____

1. What is your pain RIGHT NOW?

No Pain _____ Worst Pain Possible

0 1 2 3 4 5 6 7 8 9 10

2. What is your TYPICAL or AVERAGE pain?

No Pain _____ Worst Pain Possible

0 1 2 3 4 5 6 7 8 9 10

3. What is your pain AT ITS BEST (How close to "0" does your pain get at its best)?

No Pain _____ Worst Pain Possible

0 1 2 3 4 5 6 7 8 9 10

4. What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?

No Pain _____ Worst Pain Possible

0 1 2 3 4 5 6 7 8 9 10

OTHER COMMENTS: _____

Examiner Reprinted from Spine, 18, Von Korff M, Deyo RA, Cherkin D, Barlow SF, Back pain in primary care: Outcomes at 1 year, 855-862, 1993, with permission from Elsevier Science.

(OFFICE USE ONLY) 1 ____ 2 _____

PATIENT INITIALS _____

ACTIVITIES OF DAILY LIVING

DIRECTIONS: Assess your ability / lack of ability to complete the following activities.

Activity	CAN COMPLETE			CANNOT COMPLETE	N/A
	Without Pain or Difficulty	***With Minimal*** Pain or Difficulty	***With Significant*** Pain or Difficulty	Due to Pain	
Bathe/Shower	❑	❑	❑	❑	❑
Groom Hair	❑	❑	❑	❑	❑
Brush Teeth	❑	❑	❑	❑	❑
Use Toilet	❑	❑	❑	❑	❑
Dress Upper Body	❑	❑	❑	❑	❑
Dress Lower Body	❑	❑	❑	❑	❑
Daily Physical Activities	❑	❑	❑	❑	❑
Stand	❑	❑	❑	❑	❑
Walk	❑	❑	❑	❑	❑
Sit	❑	❑	❑	❑	❑
Squat	❑	❑	❑	❑	❑
Kneel	❑	❑	❑	❑	❑
Reach Overhead	❑	❑	❑	❑	❑
Bend Forward	❑	❑	❑	❑	❑
Turn Left	❑	❑	❑	❑	❑
Turn Right	❑	❑	❑	❑	❑
Move from Seated to Standing	❑	❑	❑	❑	❑
Sleep	❑	❑	❑	❑	❑
Eat	❑	❑	❑	❑	❑
Go Up/Down Stairs	❑	❑	❑	❑	❑
Get In/Out of Car	❑	❑	❑	❑	❑
Use Computer	❑	❑	❑	❑	❑
Focus/Concentrate	❑	❑	❑	❑	❑
Prepare Food	❑	❑	❑	❑	❑
Household Chores	❑	❑	❑	❑	❑
Carry Bag/Purse	❑	❑	❑	❑	❑
Run/Hike	❑	❑	❑	❑	❑
Other: _____	❑	❑	❑	❑	❑

PATIENT INITIALS _____

REVIEW OF SYSTEMS & ORGAN DYSFUNCTION

CONDITION	SELF	SIBLING	PARENT	GRANDPARENT
ADHD/ADD	❑	❑	❑	❑
Autism Spectrum Disorder	❑	❑	❑	❑
Allergies/Sinus Problems	❑	❑	❑	❑
Anxiety/Depression	❑	❑	❑	❑
Asthma/Difficulty Breathing	❑	❑	❑	❑
Bed Wetting	❑	❑	❑	❑
Cancer	❑	❑	❑	❑
Cerebral Palsy	❑	❑	❑	❑
Chest Pain	❑	❑	❑	❑
Constipation	❑	❑	❑	❑
Diabetes	❑	❑	❑	❑
Difficulty Sleeping	❑	❑	❑	❑
Dizziness/Vertigo	❑	❑	❑	❑
Ear Infections	❑	❑	❑	❑
Epilepsy/Seizures	❑	❑	❑	❑
Frequent Illness	❑	❑	❑	❑
Headaches/Migraines	❑	❑	❑	❑
Latching Difficulties (Infant)	❑	❑	❑	❑
Scoliosis	❑	❑	❑	❑
Trauma/Neglect	❑	❑	❑	❑
TMJ/Jaw Pain	❑	❑	❑	❑
Trouble Gaining Weight	❑	❑	❑	❑
* Organic / System Problems	❑	❑	❑	❑

* **Select ALL that apply:** ❑ Digestive ❑ Heart ❑ Liver ❑ Stomach ❑ Pancreas ❑ Reproductive ❑ Lung/Respiratory ❑ Urinary ❑ Kidney ❑ Vision ❑ Skin ❑ Other(s) _____ *Explain below:*

_____

_____

DEVELOPMENTAL MILESTONES

Has your child been reaching all developmental milestones?

❑ Yes ❑ No **(***If no, please explain):* _____

_____

_____

PATIENT INITIALS _____

Child's Name: _____ **Date:** _____

TERMS OF ACCEPTANCE

Please read the below and if you have any questions, feel free to ask one of our staff members.

RESILIENCE HEALTH CENTER NOTICE OF PRIVACY PRACTICE

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your **P**ersonal **H**ealth **I**nformation. In addition we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or as dictated by our office policy, we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. In addition, you will find we have placed several copies in report folders labeled '**HIPAA'** on tables in the reception. Once you have read this notice, please sign the last page, and return only the signature page (page 2) to our front desk receptionist. Keep this page for your records.

PERMITTED DISCLOSURES:

1. Treatment purposes - discussion with other health care providers involved in your care.
2. Inadvertent disclosures - open treating area mean open discussion. If you need to speak privately to the doctor, please let our staff know so we can place you in a private consultation room.
3. For payment purposes - to obtain payment from your insurance company or any other collateral source.
4. For workers compensation purposes - to process a claim or aid in investigation.
5. Emergency - in the event of a medical emergency we may notify a family member.
6. For Public health and safety - in order to prevent or lessen a serious or eminent threat to the health or safety of a person or general public.
7. To Government agencies or Law enforcement - to identify or locate a suspect, fugitive, material witness or missing person.
8. For military, national security, prisoner and government benefits purposes.
9. Deceased persons - discussion with coroners and medical examiners in the event of a patient's death.
10. Telephone calls or emails and appointment reminders - we may call your home and leave messages regarding a missed appointment or apprize you of changes in practice hours or upcoming events.
11. Change of ownership- in the event this practice is sold, the new owners would have access to your PHI.

YOUR RIGHTS:

1. To receive an accounting of disclosures.
2. To receive a paper copy of the comprehensive "Detail" Privacy Notice.
3. To request mailings to an address different than residence.
4. To request Restrictions on certain uses and disclosures and with whom we release information to, although we are not required to comply. If, however, we agree, the restriction will be in place until written notice of your intent to remove the restriction.
5. To inspect your records and receive one copy of your records at no charge, with notice in advance.
6. To request amendments to information. However, like restrictions, we are not required to agree to them.
7. To obtain one copy of your records at no charge, when timely notice is provided (72 hours). X-rays are original records and you are therefore not entitled to them. If you would like us to outsource them to an imaging center, to have copies made, we will be happy to accommodate you. However, you will be responsible for this cost.

COMPLAINTS: If you wish to make a formal complaint about how we handle your health information, please call Dr. Rob Michaud (269) 389-0345. If he is unavailable, you may make an appointment with our receptionist to see her within 72 hours or 3 working days. If you are still not satisfied with the manner in which this office handles your complaint, you can submit a formal complaint to DHHS, Office of Civil Rights, 200 Independence Ave. SW, Room 509F HHH Building, Washington DC 20201.

(Please see next page)

PATIENT INITIALS _____

RESILIENCE HEALTH CENTER NOTICE REGARDING YOUR RIGHT TO PRIVACY (CONTINUED)

I have received a copy of Resilience Health Center Patient Privacy Notice. I understand my rights as well as the practice's duty to protect my health information, and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this "Notice of Privacy Practice" at a time in the future and will make the new provisions effective for all information that it maintains past and present. I am aware that a more comprehensive version of this "Notice" is available to me and several copies kept in the reception area. At this time, I do not have any questions regarding my rights or any of the information I have received.

Guardian Name (Printed): _____ **Date:** _____

Guardian Signature: _____ **Guardian DOB:** _____

AUTHORIZATION FOR X-RAYS

X-rays are utilized in the office to help location and analyze **vertebral subluxations**. These x-rays are not to be used to investigate for medical pathology. The doctors of Resilience Health Center do not diagnose or treat medical conditions; however if any abnormalities are found, they will be brought to your attention so that you can seek proper medical advice. By my signature below I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

Guardian Signature: _____ **Date:** _____

(*Females Only*) Please check the box that applies to you - To the best of my knowledge:

❏ My child **IS <u>NOT</u>** pregnant at this time

❏ My child **IS/I** believe my child **MAY BE** pregnant, therefore I **DO <u>NOT</u>** authorize Resilience Health Center to X-ray my child at this time.

Guardian Signature: _____ **Date:** _____

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I authorize Resilience Health Center to release all necessary information concerning my health condition to my billing company, insurance company, attorney, and/or adjuster in order to process any claim for reimbursement of charges incurred by me. In addition, I authorize Resilience Health Center to release any information regarding my health condition to other health care providers involved in my care. This assignment will remain in effect until revoked by me in writing. I agree that a photocopy of this form is to be considered as valid as the original. I confirm that all information I have provided is true and correct to the best of my knowledge. I confirm that I have read and fully understand this agreement and authorize Resilience Health Center to proceed with chiropractic tests, diagnosis, analysis, and adjustments.

Guardian Signature: _____ **Date:** _____

PATIENT INITIALS _____

INFORMED CONSENT TO CARE

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as “informed consent” and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an “arterial dissection” that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately a percentage of these patients will experience a stroke.

The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events/ per one million persons/year and risk of death has been estimated as 104 per one million users.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name: _____ **Signature:** _____ **Date:** _____

Parent or Guardian: _____ **Signature:** _____ **Date:** _____

Witness Name: _____ **Signature:** _____ **Date:** _____

PATIENT INITIALS _____