Cornish Family Chiropractic

1911 4th St SW, Suite C | Mason City, IA 50401

# PEDIATRIC INTAKE FORM

*Today's Date*: _____

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

**Address:** _____ **City:** _____ **State:** _____ **Zip:** _____

**Parent/Guardian:** _____ **Relationship:** _____

**Phone:** _____ Verizon/US Cellular/AT&T/Sprint **Email:** _____

**Social Security #:** _____ **Gender**: M / F **Date of Birth (mm/dd/yy)** _____

**Student Status:** *Full Time / Part Time / Non-Student* *Referred by: _____

**Financial Information:** ( ) Insurance ( ) Cash ( ) Personal Injury/Auto ( )Other _____

***Primary Insurance***

**Name**: _____

**Relation to Insured**: Self / Spouse / Parent / Child / Other

**Insured's Name** _____ **M / F**

**Address:**_____

**City:** _____ **State:** _____ **Zip**: _____

**Phone**: _____ **Date of Birth**: _____

***Secondary Insurance***

**Name**: _____

**Relation to Insured**: Self / Spouse / Parent / Child / Other

**Insured's Name** _____ **M / F**

**Address:**_____

**City:**_____ **State:** _____ **Zip**: _____

**Phone**: _____ **Date of Birth**: _____

**Who is responsible for payment?** Self / Other _____*(Relationship)*_____

**Full Name**: _____ **Phone**: _____

**Address**: _____ **City**: _____ **State**: _____ **Zip**:_____

## Prenatal / Infant

**During pregnancy did you use:** Drugs/Medications
Tobacco/Alcohol

*Explain*: _____

**Describe Delivery:**

__ Labor Was Induced __ Forceps/Vacuum Extraction
__ C-Section Delivery __ Labor Was Doctor Assisted
__ Premature Delivery __ Doctor Pulled or Twisted Baby

*Other Delivery Complications*:

_____

_____

Birth Weight: _____ Birth Length: _____

Ultrasound During Pregnancy **Y / N** How Many _____
Did You/Are You Breastfeeding **Y / N** How Long _____
Formula Fed/Feeding **Y / N** How Long _____
What Age Did You Introduce :
Solids: _____
Cows Milk: _____

***Other Comments / Concerns:***

_____

## Health

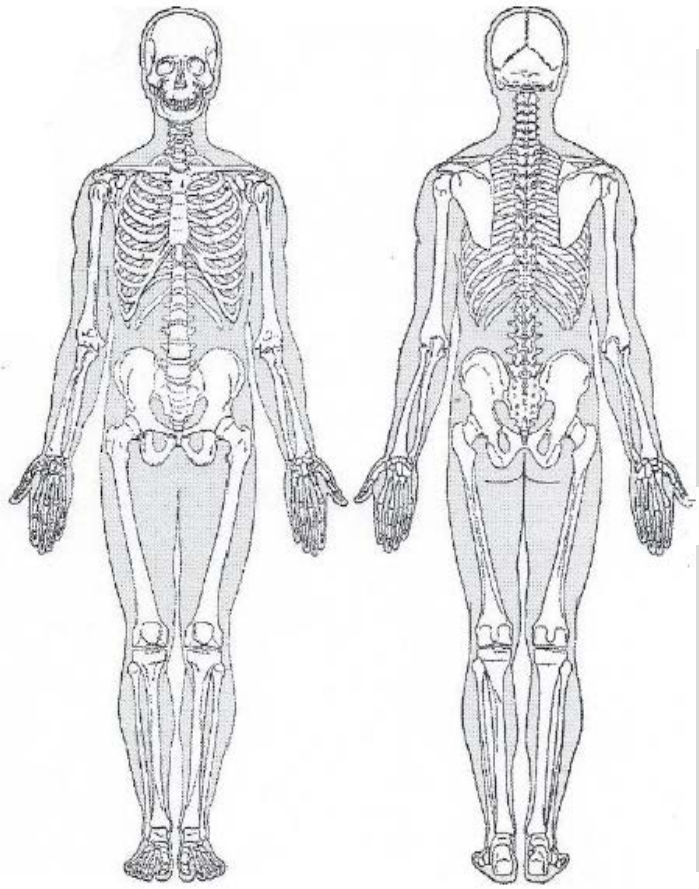
Does your child have difficulty sleeping? **Y / N**
*Explain*: _____
Has your child been hospitalized or had surgery? **Y / N**
*Explain*: _____
Have you noticed your child is
*Nervous - Twitches - Shakes - Exhibits Rocking Behavior*
*Explain*: _____
Involved in any high impact/contact sports? **Y / N**
*(Soccer, Football, Martial Arts, Cheerleading, etc)*
*List*: _____
Any food allergies or intolerance? **Y / N**
*Explain*: _____
Received all recommended vaccinations? **Y / N**
Stress Levels on scale of 1-10 (10 being highest):
*School* _____ *Personal* _____

## Health History

*Please check each of the conditions or diseases that the child now or has had in the past. While they may seems unrelated to the purpose of the appointment, they can affect the overall diagnosis, care plon and the possibility of being accepted for care.*

__ Acid Reflux __ Constipation __ Frequent Cold/ Cough
__ Asthma __ Diarrhea __ Hyperactivity
__ Bed Wetting __ Ear Infections __ Learning Disorders
__ Sleep Difficulties __ Colic __ Difficult Weight Gain
Other: _____

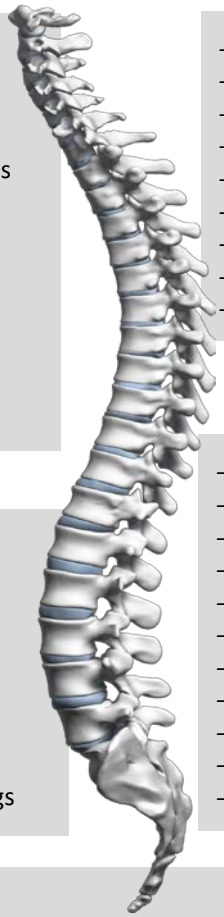
## *Please indicate areas of concern:*



*Please check each of the diseases or conditions that you have or have had in the past. While they may seem unrelated to the purpose of the appointment, they can affect the overall diagnosis, care plan, and the possibility of being accepted for care.*

__Thyroid Problems
__Sore Throat
__Stiff Neck
__Radiating Arm Pain
__Hand/Finger Numbless
__Asthma
__Allergies
__High Blood Pressure
__Low Blood Pressure
__Heart Murmer
__Pacemaker
__Acid Reflux

__Headaches
__Migraines
__Dizziness
__Sinus Problems
__Allergies
__Fatigue
__Head Colds
__Vision Problems
__Difficulty Concentrating



__Constipation
__Colitis
__Diarrhea
__Gas Pain
__Irritable Bowel
__Bladder Problems
__Menstrual Problems
__Low Back Pain
__Pain/Numbness in Legs

__Middle Back Pain
__Congestion
__Difficulty Breathing
__Bronchitis
__Pneumonia
__Gallbladder Conditions
__Stomach Problems
__Diabetes
__Gastritis
__Hepatitis
__Kidney Problems

## Health Concerns

__ Nausea/ Vomiting
__ Overweight
__ Detachment/Distant
__ Colic / Acid Reflux
__ Learning Disorders
__ Difficulty Gaining Weight
__ Anxiety/Depression
__ Diabetes
__ Frequent Sickness
__ Irritability/Nervous
__ Headaches
__ Sinus Trouble/ Allergies
__ Asthma/ Chronic Bronchitis
__ Constipation/Diarrhea
__ Bed Wetting
__ ADD/ADHD
__ Fatigue/ Sleep Issues
__ Back/Neck Pain/Stiffness
__ Ear /Other Infections

Other/Explain: _____
_____
_____
_____

## Vitamins / Supplements

__ Multi-Vitamin
__ Vitamin D3
__ Fish Oil / Omega-3
__ Probiotics

**Medications / Other** _____
_____
_____
_____

*Is there someone we may thank for referring you to our office?* _____

Have you seen or heard of our office beacuse of:

___ *Sign* ___ *Community Event* ___ *Mailing* ___ *Social Media* *Other* _____

***Patient Signature*** _____

***Parent/Guardian Signature*** _____

*Thank you for choosing Cornish Family Chiropractic for your wellness! We look forward to working with you.*

Cornish Family Chiropractic

1911 4th St SW, Suite C, Mason City IA 50401

## Acknowledgement of Notice of Privacy Practices

I acknowledge that I have read a copy of this office's HIPPA Notice of Privacy Practices.

{Please Print Name} {Signature} {Date}

OR

{Signature of Representative/Guardian}

***Authority of Representative/Guardian***

__ Parent __ Guardian __Power of Attorney

__Other _____

## Consent for Treatment

*I hereby grant Dr. Brett Cornish authority to perform any chiropractic care as he deems necessary or advisable for my diagnoses and treatment, including diagnostic imaging.*

{Patient or Parent of Minor} {Date} {Doctor's Initials}

## Financial Policy

- Payment for services is due at the time services are rendered
  - We accept cash, checks, Visa, MasterCard, and Discover
  - We reserve the right to collect before services are rendered
- All charges are your responsibility whether the insurance company pays or not
  - Not all services are a covered benefit. Benefits may vary on different insurance plans. It is your responsibility to verify your insurance coverage; however, our office staff will gladly assist you with verification to the best of our ability
  - Fees for non-covered services, deductibles, and co-payments are due at the time of treatment
  - If your insurance company does not pay your claim within a reasonable time frame, or if coverage for a particular service or supply is denied, we may require you to follow up with your insurance company and/or pay the balance due
- Unless you are insured by Medicare or an insurance group which our doctor is a participating member, or double insured (for procedure being performed), it is our policy to collect 100% payment at the time the services are rendered
- If you are a member of an HMO or Managed Care Program, or have a PCP (Primary Care Physician), you are responsible for contacting your PCP for a referral number prior to your visit if one is required by your agreement with your insurance company
- We understand that temporary financial problems may affect timely payment of your balance. We ask that you speak with the front desk to set up alternate payment options for your account

{Patient or Parent of Minor} {Date}