Today's Date: _____

VITALITY
FAMILY CHIROPRACTIC

PEDIATRIC INTAKE FORM
Infant – 17 years old

PATIENT INFORMATION

Child's Name:_____ Parent/Guardian Name:_____

Gender: ☐ Male ☐ Female D.O.B:_____/_____/_____ Age_____
Current Height:_____ Current Weight:_____
Address: _____ City,
State, Zip: _____

Other Children's names/ages:
_____

Email: _____ Home Phone: _____

Cell Phone: _____ Cell Provider: _____ ☐Yes! I want to opt for text appt reminders
How did you hear about us? _____

Has your child been adjusted by a chiropractor before? ☐ YES ☐ NO
If yes, reason for those visits: _____
When was the last visit?_____

Is your child receiving care from other health professionals? ☐ YES ☐ NO
If yes, list name and specialty: _____
Who is your family's primary care physician?_____
Contact information:_____

HEALTH HISTORY

Describe the health concern that prompted this visit:_____
When did this concern begin? _____ How did this concern begin? _____

Has this condition: ☐ Worsened ☐ Stayed the same ☐ Been Intermittent

Does this interfere with: ☐ School ☐ Sleep ☐ Daily Routine
What makes this condition worse? _____
What makes this condition better? _____

Has your child seen anyone else for this concern? ☐ YES ☐ NO Type of treatment:_____
Please list any medications taken for this concern:_____

Child's birth was at: ☐ Home ☐ Birthing Center ☐ Hospital OB/Midwife/Physician was:_____

Child birth was: ☐ Natural vaginal with no medications

☐ Vaginal with interventions: ☐ Pitocin ☐Epidural ☐ Pain Medications ☐ Vacuum Extraction

☐ Forceps ☐ IV antibiotics ☐Other:_____

C-Section: ☐ Scheduled ☐ Emergency

☐ Adopted ☐ Prenatal history unknown ☐ Birth history unknown

Was your child at any time during your pregnancy in a constrained position?: ☐ YES ☐ NO ☐ UNSURE

If yes, please describe: ☐ Breech ☐ Transverse ☐ Face/Brow presentation

Complications during pregnancy: ☐YES ☐ NO (If yes, describe)_____

Medications during pregnancy: ☐ YES ☐ NO
(If yes, describe)_____
If so, which ones and how often? (include Over-the-counter):_____
_____

Exposure to drugs, alcohol, cigarettes, or secondhand smoke during pregnancy: ☐ YES ☐ NO
(If yes, describe)_____

Birth Weight: _____lbs _____oz Birth Height:_____
Please list all of your child's hospitalizations and surgical history (include year):
_____

_____
Please list any major injuries, accidents, falls and/or fractures your child has sustained in his/her lifetime:
_____

The human body is designed to be healthy. The primary system in the body, which coordinates health and function, is the nervous system. Your nervous system is surrounded and protected by the bones of the spine, called vertebrae. Many of the common health challenges that adults experience has their origins during the developmental years, starting at birth. Layers of damage to the spine and nervous system occur as a result of various traumas, toxins, and emotional stress. The result may be misalignment to the spinal column and damage to the nervous system – a condition called Vertebral Subluxation. Please answer the following questions to give us a better understanding about your child's state of wellness and factors which may be contributing to vertebral subluxation and impeding your child's ability to heal.

What signals has your child's body been communicating?

PAST	PRESENT		PAST	PRESENT		PAST	PRESENT	
☐	☐	Asthma	☐	☐	Frequent Diarrhea	☐	☐	Slow Weight Gain
☐	☐	Respiratory Tract Infections	☐	☐	Constipation	☐	☐	Asymmetrical Crawling
☐	☐	Sinus Problems	☐	☐	Flatulence	☐	☐	Asymmetrical Gait
☐	☐	Ear Infections	☐	☐	Headaches/Migraines	☐	☐	Weight Challenges
☐	☐	Tonsillitis	☐	☐	Neck Pain	☐	☐	Bed Wetting

☐ ☐ Strep Throat	☐ ☐ Torticollis/Head Tilt	☐ ☐ Sleeping Problems
☐ ☐ Frequent Colds/Croup	☐ ☐ Trouble Nursing	☐ ☐ Night Terrors
☐ ☐ Recurrent Fevers	☐ ☐ Back Pain	☐ ☐ Tip Toe Walking
☐ ☐ Eczema	☐ ☐ Growing Pains	☐ ☐ Seizures
☐ ☐ Rashes	☐ ☐ Scoliosis	☐ ☐ Tremors/Shaking
☐ ☐ Allergies	☐ ☐ Red, Swollen, Painful Joints	☐ ☐ ADD/ADHD
☐ ☐ Food Sensitivities	☐ ☐ Colic	☐ ☐ Autism
☐ ☐ Digestive Issues	☐ ☐ Frequent Crying Spells/Colic	

Other:_____

What is your primary goal for your child at our clinic?_____

_____

Our goal is to provide a detailed assessment of your child's current health status and provide you with the resources for a highly engaged and healthy child whose body is functioning at its absolute peak potential while they grow. Essential to this healthy growth is a properly functioning nervous system that is able to function free from interference called subluxation. Dr. Katheryne is certified in both pregnancy and pediatrics, is certified in the Webster Technique, and is a member of the International Chiropractic Pediatric Association.

X-RAY AUTHORIZATION

AS YOUR HEALTHCARE PROVIDER, WE ARE LEGALLY RESPONSIBLE FOR YOUR CHIROPRACTIC RECORDS. WE MUST MAINTAIN A RECORD OF YOUR X-RAYS IN OUR FILES.
AT YOUR REQUEST, WE WILL PROVIDE YOU WITH A COPY OF YOUR X-RAYS IN OUR FILES.
THE FEE FOR COPYING YOUR X-RAYS ON A DISC IS $15.00. THIS FEE MUST BE PAID IN ADVANCE.

DIGITAL X-RAYS ON CD WILL BE AVAILABLE WITHIN 72 HOURS OF PREPAYMENT ON ANY REGULAR PRACTICE HOURS DAY.
PLEASE NOTE: X-RAYS ARE UTILIZED IN THIS OFFICE TO HELP LOCATE AND ANALYZE **VERTEBRAL SUBLUXATIONS.**
THESE X-RAYS ARE NOT USED TO INVESTIGATE FOR MEDICAL PATHOLOGY. THE DOCTORS OF OZNER FAMILY CHIROPRACTIC DO NOT DIAGNOSE OR TREAT MEDICAL CONDITIONS; HOWEVER, IF ANY ABNORMALITIES ARE FOUND, WE WILL BRING IT TO YOUR ATTENTION SO THAT YOU CAN SEEK PROPER MEDICAL ADVICE.
BY SIGNING BELOW, YOU ARE AGREEING TO THE ABOVE TERMS AND CONDITIONS.

_____ _____
PRINT YOUR NAME HERE **DATE**

_____ _____
SIGNATURE **YOUR AGE**

FEMALE PATIENTS ONLY: TO THE BEST OF MY KNOWLEDGE, **I BELIEVE I AM NOT PREGNANT** AT THE TIME X-RAYS ARE TAKEN AT VITALITY FAMILY CHIROPRACTIC

_____ _____
SIGNATURE **DATE**

DO NOT WRITE BELOW THIS LINE • DO NOT WRITE BELOW THIS LINE • DO NOT WRITE BELOW THIS LINE

Sex: ☐ M ☐ F

☐ Lat Cervical ☐ Flex/Ext

CM	Kvp	Time	MAS
☐10-11	☐78	☐1/24	12.5
☐12-13	☐	☐1/20	15
☐14-15		☐1/15	20
☐16-17		☐1/10	30
		☐2/15	40

MA 300 Size 8x10

☐ Lower Cervical

CM	Kvp	Time	MAS
☐14-15	☐70	☐1/10	20
☐16-17	☐	☐2/15	30
☐18-19		☐3/20	40
☐20-21		☐2/10	50
☐22-23			

MA 300 Size 8x10

☐ APOM

CM	Kvp	Time	MAS
☐14-15	☐70	☐1/10	20
☐16-17	☐	☐2/15	30
☐18-19		☐3/20	40
☐20-21		☐2/10	50
☐22-23			

MA 300 Size 8x10

Other
View _____

CM_____ Kvp _____

MAS_____ MA_____

Size _____

☐ Lateral Thoracic

CM	Kvp	Time	MAS
☐22-23	☐80	☐1/15	20
☐24-25	☐	☐1/10	30
☐26-27		☐2/15	40
☐28-29		☐2/10	50
☐30-31		☐1/4	75
☐32-33		☐3/10	90
☐34-35		☐2/5	120
☐36-37		☐1/2	150

MA 300 Size14x17

☐ A-P Thoracic

CM	Kvp	Time	MAS
☐16-17	☐75	☐1/20	17
☐18-19	☐	☐1/15	22
☐20-21		☐1/10	30
☐22-23		☐2/15	40
☐24-25		☐2/10	50
☐26-27		☐1/4	75
☐28-29		☐3/10	90
☐30-31		☐2/5	120

MA 300 Size14x17

☐ Lateral Lumbar

CM	Kvp	Time	MAS
☐26-27	☐88	☐2/10	30
☐28-29	☐90	☐1/4	40
☐30-31	☐92	☐3/10	50
☐32-33	☐94	☐2/5	70
☐34-35	☐96	☐1/2	90
☐36-37	☐	☐3/5	120
☐38-39		☐4/5	160
☐40-41		☐1	200
☐42-43		☐1 1/2	
		☐2	

MA 200 Size 14x17

☐ A-P Lumbar

CM	Kvp	Time	MAS
☐20-21	☐76	☐1/15	40
☐22-23	☐78	☐1/10	50
☐24-25	☐80	☐2/15	75
☐26-27	☐	☐2/10	90
☐28-29		☐1/4	120
☐30-31		☐3/10	150
☐32-33		☐2/5	120
☐34-35		☐1/2	170
☐36-37		☐3/5	210
☐38-39		☐4/5	
☐40-41		☐1	
☐42-43		☐1 1/2	
		☐2	

MA 300 Size 14x17

Notes: _____
_____
_____
_____
_____
_____
_____

CA Initials:

_____

Terms of Acceptance

In order to provide for the most effective healing environment, most effective application of chiropractic procedures, and the strongest possible doctor-patient relationship, it is our wish to provide each patient with a set of parameters and declarations that will facilitate the goal of optimum health through chiropractic.

To that end, we ask that you acknowledge the following point regarding chiropractic care and the services that are offered through this clinic:

A. Chiropractic is a very specific science, authorized by law to address spinal health concerns and needs. Chiropractic is a separate and distinct science, art and practice. It is not the practice of medicine.
B. Chiropractic seeks to maximize the inherent healing power of the human body by restoring normal nerve functions through the adjustment of spinal subluxation(s). Subluxations are deviations from normal spinal structures and configurations that interfere with normal nerve processes.
C. The chiropractic adjustment process, as defined in the law of this jurisdiction, involves the application of a specific directional thrust to a region or regions of the spine with the specific intent of re-positioning misaligned spinal segments. This is a safe, effective procedure applied over one million times each day doctors of chiropractic in the United States alone.
D. A thorough chiropractic examination and evaluation is part of the standard chiropractic procedure. The goal of this process is to identify any spinal health problems and chiropractic needs. If during this process, any condition or question outside the scope of chiropractic is identified, you will receive a prompt referral to an appropriate provider or specialist, according to the initial indications of the need.
E. Chiropractic does not seek to replace or compete with your medical, dental or other type(s) of health professionals. They retain responsibility for care and management of medical conditions. We do not offer advice regarding treatment prescribed by others.
F. Your compliance with care plans, home and self-care, etc., is essential to maximum healing and optimal health though chiropractic
G. We invite you to speak frankly to the doctor on any matter related to your care at this facility, its nature, duration, or cost, in what we work to maintain as a supporting, open environment.

By my signature below, I have read and fully understand the above statements.

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my satisfaction. I therefore accept chiropractic care on this basis.

_____ _____

(Signature) **(Date)**

Notice of Privacy Practices Acknowledgement

I understand that I have certain rights of privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

1. Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations, such as quality assessments and physicians' certifications.

I acknowledge that I may request your NOTICE OF PRIVACY PRACTICES containing a more complete description of the uses and disclosures of my health information. I also understand that I may request, in writing, that you restrict how my private information is used to disclosed to carry out treatment, payment, or healthcare operation. I also understand you are not required to agree to my requested restrictions, but if you agree, then you are bound to abide by such restrictions.

_____ _____

(Signature) **(Date)**

INFORMED CONSENT FOR CHIROPRACTIC CARE

CHIROPRACTIC CARE, LIKE ALL FORMS OF HEALTH CARE WHILE OFFERING CONSIDERABLE BENEFITS MAY ALSO PROVIDE SOME LEVEL OF RISK. THIS LEVEL OF RISK IS MOST OFTEN VERY MINIMAL, YET IN RARE CASES, INJURY HAS BEEN ASSOCIATED WITH CHIROPRACTIC CARE. THE TYPES OF COMPLICATIONS THAT HAVE BEEN REPORTED SECONDARY TO CHIROPRACTIC CARE INCLUDE: SPRAIN/STRAIN INJURIES, IRRITATION OF A DISC CONDITION, AND RARELY, FRACTURES. ONE OF THE RAREST COMPLICATIONS ASSOCIATED WITH CHIROPRACTIC CARE OCCURRING AT A RATE BETWEEN ONE INSTANCE PER ONE MILLION TO ONE PER TWO MILLION CERVICAL SPINE (NECK) ADJUSTMENTS MAY BE A VERTEBRAL INJURY THAT COULD LEAD TO A STROKE.

PRIOR TO RECEIVING CHIROPRACTIC CARE IN THIS CHIROPRACTIC OFFICE, A HEALTH HISTORY AND PHYSICAL EXAMINATION WILL BE COMPLETED. THESE PROCEDURES ARE PERFORMED TO ASSESS YOUR SPECIFIC CONDITIONS, YOUR OVERALL HEALTH AND IN PARTICULAR YOUR SPINAL HEALTH. THESE PROCEDURES WILL ASSIST US IN DETERMINING IF CHIROPRACTIC CARE IS NEEDED, OR IF ANY FURTHER EXAMINATIONS OR STUDIES ARE NEEDED. IN ADDITION, THEY WILL HELP US DETERMINE IF THERE IS ANY REASON TO MODIFY YOUR CARE OR PROVIDE YOU WITH A REFERRAL TO ANOTHER HEALTH CARE PROVIDER. ALL RELEVANT FINDINGS WILL BE REPORTED TO YOU ALONG WITH A CARE PLAN PRIOR TO BEGINNING CARE.

I UNDERSTAND AND ACCEPT THAT THERE ARE RISKS ASSOCIATED WITH CHIROPRACTIC CARE AND GIVE CONSENT TO THE EXAMINATION THAT THE DOCTOR DEEMS NECESSARY AND THE CHIROPRACTIC CARE, INCLUDING SPINAL ADJUSTMENTS, AS REPORTED FOLLOWING MY ASSESSMENT.

_____

PRINT PRACTICE MEMBER'S NAME HERE

_____ _____

PRACTICE MEMBER'S SIGNATURE OR GUARDIAN SIGNATURE **DATE**

IF THIS HEALTH PROFILE IS FOR A MINOR/CHILD, PLEASE FILL OUT AND SIGN BELOW WRITTEN

CONSENT FOR A CHILD

NAME OF PRACTICE MEMBER WHO IS A MINOR/CHILD _____

I AUTHORIZE DR. KATHERYNE CASTRO AND ANY AND ALL VITALITY FAMILY CHIROPRACTIC STAFF TO PERFORM DIAGNOSTIC PROCEDURES, RADIOGRAPHIC EVALUATIONS, RENDER CHIROPRACTIC CARE AND PERFORM CHIROPRACTIC ADJUSTMENTS TO MY MINOR/CHILD.

AS OF THIS DATE, I HAVE THE LEGAL RIGHT TO SELECT AND AUTHORIZE HEALTH CARE SERVICES FOR MY MINOR/CHILD. IF MY AUTHORITY TO SELECT AND AUTHORIZE CARE IS REVOKED OR ALTERED, I WILL IMMEDIATELY NOTIFY VITALITY FAMILY CHIROPRACTIC.

_____ _____

DATE GUARDIAN SIGNATURE **AND** RELATIONSHIP TO MINOR / CHILD

_____ _____

WITNESS SIGNATURE (OFFICE STAFF) **DATE**

FAMILY HEALTH HISTORY

THIS FORM IS TO ASSIST THE DOCTORS BY PROVIDING PAST HEALTH HISTORY INFORMATION FOR THEIR REVIEW.

_____ _____

DATE PLEASE PRINT YOUR NAME HERE

CONDITION	SPOUSE	SON	DAUGHTER	MOTHER	FATHER
ARM PAIN					
ARTHRITIS					
ASTHMA					
ADD/ADHD					
ALLERGIES					
BACK TROUBLE					
BED WETTING					
CANCER					
CARPAL TUNNEL					
DECEASED					
DIABETES					
DIGESTIVE PROBLEMS					
DISC PROBLEMS					
EAR INFECTIONS					
FIBROMYALGIA					
HEADACHES					
HEART DISEASE					
HIGH BLOOD PRESSURE					
HIP PAIN					
LEG PAIN					
MENSTRUAL DISORDER					
MIGRAINES					
NECK PAIN					
SCOLIOSIS					
SHOULDER PAIN					
SINUS TROUBLE					
TMJ					

No-Call/No-Show Policy

Due to several No-Call/No-Show appointments and out of courtesy for other practice members who may need a certain time slot, we have found it necessary to implement a No-Call/No-Show Policy and fee.

We ask that you please understand the reason behind this policy is that time is valuable to everyone: you, other patients, doctors and assistants.

No-Call/No-Show Policy

We understand that life happens and schedules change, however we do ask that if you are unable to make your appointment, please call or text us when you receive your appointment reminder (within two hours) to cancel and reschedule. 24 HOURS NOTICE IS IDEAL. If you miss your appointment and did not call ahead to inform us, you will be charged a $25 NO-CALL/NO-SHOW Missed Appointment Fee that will be assessed to your card on file.

First Offense- No charge, graceful warning

Second (+) offense- $25

Running Late

We pride ourselves on doing our best to still get you adjusted when you are running late to your scheduled appointment, however we ask that you please let us know by call or text if you will be more than 10 minutes late. Please know that if you are running more than 10 minutes late, you have run into the next time slot and may have to wait for the members scheduled during that time to get adjusted before you see the doctor.

We thank you for your understanding and consideration as we are a growing office and want to continue to serve everyone to the best of our ability.

Yours in Health and Healing,

Vitality Family Chiropractic

CONTINUE TO NEXT PAGE

No-Call/No-Show Policy

Please Read Completely

I,_____ will make every effort to give at least two hours advance notice if I need to cancel and reschedule my appointment. I understand that 24-hour notice is ideal and will do my best to let the front desk know as soon as possible that I will be late or needing to reschedule my appointment. I agree, permit and authorize Vitality Family Chiropractic the right to charge my credit card $25 if I do not call or show to my scheduled appointment.

I have read fully, understand and agree to the above.

_____ _____

Patient Signature Date

VITALITY
FAMILY CHIROPRACTIC

Authorization Form

Patient Name:_____

Address:_____City:_____State:_____

Phone Number:_____-_____-_____ Email:_____

THE PATIENT ABOVE AUTHORIZES VITALITY FAMILY CHIROPRACTIC, LLC TO USE AND/OR DISCLOSE PROTECTED HEALTH INFORMATION IN ACCORDANCE WITH THE FOLLOWING:

SPECIFIC AUTHORIZATIONS

____ Yes / No I give Vitality Family Chiropractic, LLC permission to leave messages regarding appointments, finances, and other office concerns via phone call, voicemail, text or email. Vitality Family Chiropractic, LLC may also leave messages or discuss my care with the following family member or other:_____

____Yes / No I give Vitality Family Chiropractic, LLC permission to provide care for me in an open room where other patients are also being cared for. I am aware that other person(s) in the office may overhear some of my protected health information during my care. Should I need to speak with the Doctor at any time in private, the Doctor will provide a room for these conversations.

____ Yes / No I give Vitality Family Chiropractic, LLC permission to use my name and/or picture on office picture boards, testimonials, thank you boards, referral boards and social media sites.

____ Yes / No I give Vitality Family Chiropractic, LLC permission to use and disclose to other Healthcare Practitioners, Health Insurance Companies and attorneys my protected health information and in accordance with the directives listed above.

RIGHT TO REVOKE AUTHORIZATIONS

You have the right to revoke this authorization, in writing, at any time. You may revoke this authorization by mailing or hand delivering a written notice to Vitality Family Chiropractic, LLC. The written notice must contain the following information:

- Your name and date of birth
- A clear statement of your intent to revoke this authorization
- The date of your request
- Your signature

The revocation will be effective on the date Vitality Family Chiropractic, LLC receives it. You have a right to refuse to sign this authorization. If you refuse to sign this authorization, Vitality Family Chiropractic will not refuse to provide care.

_____ _____

Print Patient Name Date

_____

Signature of Patient or Representative or Legal Guardian