Full Potential Chiropractic

186 Burrill Street ~ Swampscott, MA ~ 01907 Phone: 781.593.2388 Fax: 781.593.2399

Pediatric Intake Form

Please complete all questions fully so we may best help your child.

Child's Legal Name:		**Date:**
What he/she prefers to be called:		
Address:	**City/State/Zip:**	
Home Phone:	**Parent's Cell Phone:**	
Birth date:	**Age:**	**Social Security Number:**
Current School:		
Mother's Name:	**Father's Name:**	
Sibling's name(s) and age(s):		
Favorite Hobbies or Interests:		

Please select any applicable reasons for pursuing chiropractic care for your child:

_____ He/She is continuing care from another chiropractic office.

_____ I recently had my spine checked and see the value in family care.

_____ I am concerned about his/her health and looking for answers.

_____ He/She has a specific condition and concerns me.

If so, please explain: _____

_____

_____

Who may we thank for referring your child to our office?_____

Is this the result of an auto or work injury?_____If so, when?_____

Do you have other family members with similar health concerns?_____ If so, who?_____

Other doctors he/she has seen for this problem:_____

Has he/she ever been diagnosed with cancer? _____If so, what kind?_____

Surgeries your child has had: _____

Known allergies:_____

Antibiotics and number of doses your child has taken:

During the past 6 months:_____ During his/her lifetime: _____

List of current medications:_____

List of past medications: _____

Does he/she have health insurance?_____Insurance provider:_____

Policy #:_____Policy Holder:_____

In order to better understand your child's level of health, please circle any of the following body signals you have noticed your child currently or previously displaying.

Headaches Postural Imbalances Growing pains Scoliosis Asthma Allergies

Ear Infections Seizures Digestive Problems Bedwetting PDD/Autism ADD/ADHD

Other:_____

<u>Prenatal History:</u>

Adopted? _____

Complications during pregnancy? _____If so, explain: _____

Ultrasounds during pregnancy?_____If so, how many?_____

Medications/drugs/caffeine during pregnancy? _____

If so, please list type and amount: _____

_____

_____

Cigarette/alcohol use during pregnancy? ( ) Yes ( ) No If yes, type:_____amount:_____

Circle location of birth: hospital birthing center home

Circle any birth interventions: induced labor forceps vacuum extracted C-section

mother medicated (Pitocin, etc.); list: _____

baby given medications after delivery; list: _____

Complications during delivery? _____ If so, explain: _____

Genetic Disorders/Disabilities? _____ If so, explain: _____

Breast fed? _____ How long? _____Formula Fed? _____ How long? _____

According to the National Safety Council, approximately 50% of children fall head first from a high place during the first year of life (i.e. a bed, a changing table, down stairs, etc.).

Was this the case with your child?_____If so, explain:_____

_____

Is/has your child engaged in any high impact/contact type sports (i.e. soccer, football, gymnastics, hockey, baseball, cheerleading, martial arts, etc.)?_____If so, please list:_____

_____

_____

The above information is true and accurate to the best of my knowledge.

_____ _____ _____

Parent/Guardian Signature Relationship to Patient Date

Pediatric Stress Test

The following areas of stress can cause misaligned vertebrae (subluxation).
Which of these stresses do you recognize in your child?
Please circle when he/she experienced these stresses.

Child = C Teenager = T

Physical/Emotional/Chemical Stress:			**Comments:**
Birth Trauma	C		
Slips or Falls	C	T	
Automobile Accidents	C	T	
Sports Injuries	C	T	
Physical Abuse	C	T	
Poor Posture	C	T	
Work Injuries		T	
Extensive Computer Work	C	T	
Sleeping on Stomach	C	T	
Sitting on a Wallet		T	
Carrying a Heavy Purse/ Backpack/Child	C	T	
Repetitive Lifting/Bending	C	T	
Driving for Many Hours	C	T	
Continuous Hours Sitting/Standing		T	
Relationship Stress		T	
Concealed Feelings	C	T	
Quick Tempered	C	T	
Smoker/2nd Hand Smoke	C	T	Amount:_____
Poor Diet/Excessive Sugar	C	T	Amount:_____
Caffeine	C	T	Amount:_____
Artificial Sweeteners	C	T	
Prescription Drugs	C	T	
Over the Counter Drugs (i.e. Tylenol, Motrin, etc.)	C	T	

Which do you feel are primary stresses?_____

The above information is true and accurate to the best of my knowledge.

_____ _____
Parent/Guardian Signature Date

_____
Relationship to Patient

NOTICE OF PRIVACY PRACTICES

The following are policies of Dr. Angela Gambale O'Brien and Dr. Jamie Engel and will be implemented unless patients notify her in writing that they do not wish to participate:

OPEN ADJUSTING ENVIRONMENT:

It is the practice of Drs. Angela Gambale O'Brien and Jamie Engel to provide chiropractic care in an "open adjusting" environment. "Open adjusting" involves several patients being in the same adjusting area at the same time. Patients may be within sight of one another and some ongoing routine details of care may be discussed within earshot of other patients and staff. The environment is used for ongoing care and is NOT the environment used for taking patients histories or performing examinations. These procedures are complete in a private, confidential setting.

We are requesting this authorization of you due to various interpretations under federal law with respect to what is known as "incidental disclosures" of health information. It is our view that the kinds of matter related in an "open adjusting" environment are incidental matters. In the event you or someone else would not agree with us, we are providing this disclosure.

It is our desire for our staff to use the name, address, e-mail address and/or telephone number for the purpose of contacting you to advise you about health related meetings, workshops, and important office information such as office hour changes and cancellations.

We would like to use your name, signature, photographs and/or radiographs on our "Thank You Board" , our "Patient of the Week," and our "Kids Picture Wall" . Please let us know if you wish not to participate.

It is our desire for our staff to use your name and/or signature on our sign-in sheets in order to verify your office visit.

As a courtesy to our patients, if you miss an appointment, it is our policy to call your home or cell phone to reschedule your appointment time. If you are not available, we will leave you a reminder message on your answering machine or with the person answering the phone. No personal health information will be disclosed during this recording other than the date and time of your scheduled appointment.

The use of this information is intended to make your experience with our office more efficient, productive, and to further enhance your access to quality chiropractic care. If you choose to not authorize the use of this information, your decision will have no adverse affect on your care from Drs. Angela Gambale O'Brien and Jamie Engel or on your relationship with our staff.

Drs Angela Gambale O'Brien and Jamie Engel reserves the right to change this notice and to make the revised Privacy Notice effective for all your protected health information that it contains. Each time you are a patient at Drs. Angela Gambale O'Brien and Jamie Engel's office, we will offer you a copy of current notice in effect.

EFFECTIVE DATE:

This notice is in effect as of September 23, 2008.

ACKNOWLEDGMENT:

I acknowledge that I have been offered to review a copy of the Notice if Privacy Practices.

_____	_____	_____
Name of Individual (print)	Signature of Individual	Date

If Patient is a Minor,

_____	_____	_____
Signature of Parent/Guardian	Relationship to Patient	Date

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Swampscott, MA 01907
(781) 593 -2388

ASSIGNMENT OF BENEFITS

I hereby instruct and direct my insurance company to pay by check directly to this office for the professional or chiropractic expense benefits allowable, **otherwise** payable to me under my current insurance policy as payment towards the total charges for professional services rendered by this office.

A photocopy of this assignment shall be considered as effective and valid as the original.

RELEASE INFORMATION

I authorize this office to release any medical information pertinent to my care to my insurance company, adjuster, and/or attorney involved in this case, and I hereby release this office of any consequence thereof.

FINANCIAL RESPONSIBILITY

I agree to be financially responsible for all charges incurred at this office including my insurance deductible, co-payment and any services rejected by my insurance company.

_____ _____

Patient Signature Date

IF PATIENT IS A MINOR:

_____ _____

Signature of Parent/Guardian Date

_____

Relationship to Patient