

Patient's Name: _____	Date: / /
------------------------------	---------------------

Pediatric Patient Introduction Form (Birth to 12 years)

Patient's Date of Birth _____ Height ____' ____" Weight _____ lbs. Gender: M F

Your Child's Primary care physician name & location _____

Has your child had X-Rays? Yes No What body part(s)? _____ Where were they taken? _____

Parent's/Guardian's Name: _____ SS# _____ Date of Birth _____

Driver's License # _____ State of Issue _____ Marital Status _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____

How did you hear about us? _____ Email address _____

Insurance Information (If Applicable) Cash Payment Insurance Auto Accident Job Related

Please give your card to the receptionist so that a copy may be made for your file. If the patient is not the primary card holder please give fill in the following information:

Cardholder's Name _____ Driver's License # _____ Relationship to Patient _____

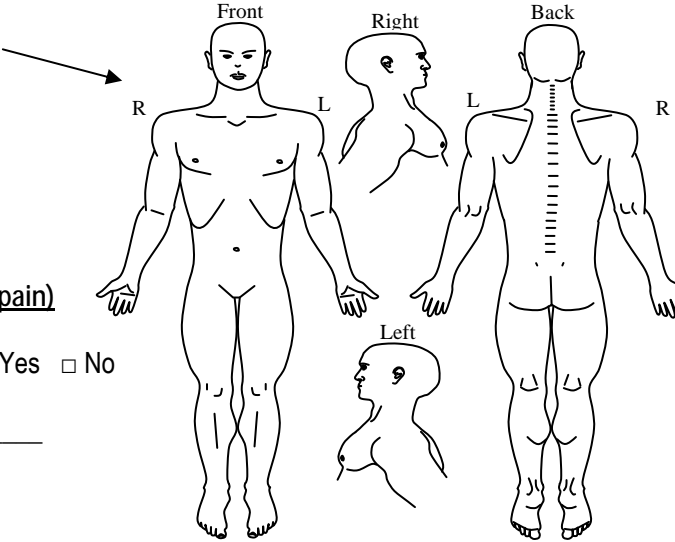
Cardholder's Birthdate ____/____/____ SS# _____ Cardholder's Employer _____

Employer's Address _____

Initial History

☺ Please answer every question so we can provide you with the best possible service. We understand some of these questions may not pertain to your child due to his/her age. If you have any questions or need help filling out this form, please ask one of the staff. We will be happy to assist you.

1. What is your child's main complaint today? _____
2. Explain how it occurred? _____
3. When did it occur? _____ Has your condition gotten worse since it started?----- Yes No
4. On the figure to the right, please mark all areas of symptoms?
5. Describe what it feels like: sharp stabbing dull ache
 tightness pulling burning numbness tingling
 pins & needles throbbing other: _____
6. On the following scale please circle the intensity/severity
 of your child's pain: (no pain) 1 2 3 4 5 6 7 8 9 10 (worst pain)
7. Do your child's symptoms radiate or shoot to other areas?----- Yes No
 a) If yes, where to? _____



8. How often do you experience your symptoms?
- a) Constantly (76-100% of the day)
 - b) Frequently (51-75% of the day)
 - c) Occasionally (26-50% of the day)
 - d) Intermittently (0-25% of the day)
9. List anything (activities, medication, etc.) that makes your child's condition better or worse: _____

10. Has your child previously received chiropractic care?----- Yes No
 a) If yes, from whom? _____
11. Has your child been treated for this complaint before?----- Yes No
 a) If yes, by whom? _____ b) When was your treatment? _____
12. Has your child's complaint caused a change or relationship with any other parts of your body? (e.g., hearing, vision, eating, sleeping, digestion, breathing, balance, strength, or other)----- Yes No
 a) If yes, what? _____
13. During the past 4 weeks how much of the time has your child's condition interfered with his/her social activities?
 a) All of the time b) Most of the time c) Some of the time d) A little of the time e) None of the time
14. Is the current complaint related to an accident?----- Yes No
 a) If yes, was it from: Auto Other (describe) _____
15. Has your child ever had any trauma or accidents other than normal bumps and bruises?----- Yes No
 a) If yes, what? _____
16. Has your child ever had any illnesses other than colds, flus, and normal childhood illnesses?----- Yes No
 a) If yes, what? _____
17. Has your child ever had surgery (prosthetic hips, knees, pacemaker or any other devices)?----- Yes No
 a) If yes, what? _____
18. Is your child taking any medication (including supplements)?----- Yes No
 a) If yes, please list the medication(s) and what it is for: _____

19. What types of activities do your child participate in? _____
20. Type of birth: Vaginal / C-section. Were pain medications used? Yes No Type _____
21. Was labor induced? Yes No If yes, why? _____
22. Do you/Did you breastfeed your child? Yes No
23. Has any of your child's blood relatives had any of the following? (check each that apply)
 Arthritis Heart disease High blood pressure Kidney disease Tuberculosis Allergies
 Thyroid disorders Cancer (type): _____ Other: _____

Neck Index

Pain Intensity

- 0) I have no pain at the moment.
- 1) The pain is very mild at the moment.
- 2) The pain comes and goes and is moderate.
- 3) The pain is fairly severe at the moment.
- 4) The pain is very severe at the moment.
- 5) The pain is the worst imaginable at the moment.

Sleeping

- 0) I have no trouble sleeping.
- 1) My sleep is slightly disturbed (less than 1 hour sleepless).
- 2) My sleep is mildly disturbed (1-2 hours sleepless).
- 3) My sleep is moderately disturbed (2-3 hours sleepless).
- 4) My sleep is greatly disturbed (3-5 hours sleepless).
- 5) My sleep is completely disturbed (5-7 hours sleepless).

Reading

- 0) I can read as much as I want with no neck pain.
- 1) I can read as much as I want with slight neck pain.
- 2) I can read as much as I want with moderate neck pain.
- 3) I cannot read as much as I want because of moderate neck pain.
- 4) I can hardly read at all because of severe neck pain.
- 5) I cannot read at all because of neck pain.

Concentration

- 0) I can concentrate fully when I want with no difficulty.
- 1) I can concentrate fully when I want with slight difficulty.
- 2) I have a fair degree of difficulty concentrating when I want.
- 3) I have a lot of difficulty concentrating when I want.
- 4) I have a great deal of difficulty concentrating when I want.
- 5) I cannot concentrate at all.

Work

- 0) I can do as much work as I want.
- 1) I can only do my usual work but no more.
- 2) I can only do most of my usual work but no more.
- 3) I cannot do my usual work.
- 4) I can hardly do any work at all.
- 5) I cannot do any work at all.

Personal Care

- 0) I can look after myself normally without causing extra pain.
- 1) I can look after myself normally but it causes extra pain.
- 2) It is painful to look after myself and I am slow and careful.
- 3) I need some help but I manage most of my personal care.
- 4) I need help every day in most aspects of self care.
- 5) I do not get dressed, I wash with difficulty and stay in bed.

Lifting

- 0) I can lift heavy weights without extra pain.
- 1) I can lift heavy weights but it causes extra pain.
- 2) I can only lift very light weights.
- 3) Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
- 4) Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
- 5) I cannot lift or carry anything at all.

Driving

- 0) I can drive my car without any neck pain.
- 1) I can drive my car as long as I want with slight neck pain.
- 2) I can drive my car as long as I want with moderate neck pain.
- 3) I cannot drive my car as long as I want because of moderate neck pain.
- 4) I can hardly drive at all because of severe neck pain.
- 5) I cannot drive my car at all because of neck pain.

Recreation

- 0) I am able to engage in all my recreation activities without neck pain.
- 1) I am able to engage in all my usual recreation activities with some neck pain.
- 2) I am able to engage in most but not all my usual recreation activities because of neck pain.
- 3) I am only able to engage in a few of my usual recreation activities because of neck pain.
- 4) I can hardly do any recreation activities because of neck pain.
- 5) I cannot do any recreation activities at all.

Headaches

- 0) I have no headaches at all.
- 1) I have slight headaches which come infrequently.
- 2) I have moderate headaches which come infrequently.
- 3) I have moderate headaches which come frequently.
- 4) I have severe headaches which come frequently.
- 5) I have headaches almost all the time.

***Neck Index Score* _____**

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Back Index

Pain Intensity

- 0) The pain comes and goes and is very mild.
- 1) The pain is mild and does not vary much.
- 2) The pain comes and goes and is moderate.
- 3) The pain is moderate and does not vary much.
- 4) The pain comes and goes and is very severe.
- 5) The pain is very severe and does not vary much.

Sleeping

- 0) I get no pain in bed.
- 1) I get pain in bed but it does not prevent me from sleeping well.
- 2) Because of pain my normal sleep is reduced by less than 25%.
- 3) Because of pain my normal sleep is reduced by less than 50%.
- 4) Because of pain my normal sleep is reduced by less than 75%.
- 5) Pain prevents me from sleeping at all.

Sitting

- 0) I can sit in any chair as long as I like.
- 1) I can only sit in my favorite chair as long as I like.
- 2) Pain prevents me from sitting more than 1 hour.
- 3) Pain prevents me from sitting more than 1/2 hour.
- 4) Pain prevents me from sitting more than 10 minutes.
- 5) I avoid sitting because it increases pain immediately.

Standing

- 0) I can stand as long as I want without pain.
- 1) I have some pain while standing but it does not increase with time.
- 2) I cannot stand for longer than 1 hour without increasing pain.
- 3) I cannot stand for longer than 1/2 hour without increasing pain.
- 4) I cannot stand for longer than 10 minutes without increasing pain.
- 5) I avoid standing because it increases pain immediately.

Walking

- 0) I have no pain while walking.
- 1) I have some pain while walking but it doesn't increase with distance.
- 2) I cannot walk more than 1 mile without increasing pain.
- 3) I cannot walk more than 1/2 mile without increasing pain.
- 4) I cannot walk more than 1/4 mile without increasing pain.
- 5) I cannot walk at all without increasing pain.

Personal Care

- 0) I do not have to change my way of washing or dressing in order to avoid pain.
- 1) I do not normally change my way of washing or dressing even though it causes some pain.
- 2) Washing and dressing increases the pain but I manage not to change my way of doing it.
- 3) Washing and dressing increases the pain and I find it necessary to change my way of doing it.
- 4) Because of the pain I am unable to do some washing and dressing without help.
- 5) Because of the pain I am unable to do any washing and dressing without help.

Lifting

- 0) I can lift heavy weights without extra pain.
- 1) I can lift heavy weights but it causes extra pain.
- 2) Pain prevents me from lifting heavy weights off the floor.
- 3) Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
- 4) Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
- 5) I can only lift very light weights.

Traveling

- 0) I get no pain while traveling.
- 1) I get some pain while traveling but none of my usual forms of travel make it worse.
- 2) I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
- 3) I get extra pain while traveling which causes me to seek alternate forms of travel.
- 4) Pain restricts all forms of travel except that done while lying down.
- 5) Pain restricts all forms of travel.

Social Life

- 0) My social life is normal and gives me no extra pain.
- 1) My social life is normal but increases the degree of pain.
- 2) Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
- 3) Pain has restricted my social life and I do not go out very often.
- 4) Pain has restricted my social life to my home.
- 5) I have hardly any social life because of the pain.

Changing degree of pain

- 0) My pain is rapidly getting better.
- 1) My pain fluctuates but overall is definitely getting better.
- 2) My pain seems to be getting better but improvement is slow.
- 3) My pain is neither getting better or worse.
- 4) My pain is gradually worsening.
- 5) My pain is rapidly worsening.

***Back Index Score* _____**

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Consent to Treatment and Privacy Policy

I _____, the undersigning parent/person having legal custody/guardianship of _____, a minor, do hereby authorize, request and direct Dr. Ashley Mayland to perform chiropractic adjustments, treatments and procedures. I further consent to examinations, consulting services, and diagnostic procedures rendered in conjunction with the adjustments, treatments, and procedures.

Release of Information

Dr. Ashley Mayland may disclose information from the patient's records to doctors, hospitals, or others for continuous care and to any third party who requires that information in order to fulfill an obligation benefiting the patient.

Responsibility for Payment

I acknowledge my responsibility to and agree to pay in full for the professional services rendered. I understand that if the doctor may bill my health insurer for the services, such billing does not relieve me of my responsibility to pay for the services. I also understand a charge will be made for broken appointments unless 24 hours notice is given. I agree to pay for any costs incurred as a result of sending my bill to a collection agency or any other legal action as well as 1.5% interest per month on any money owed for service rendered.

Informed Consent of Risks

I understand that chiropractic care, as with any health intervention, has inherent risks. These risks, though rare, could occur ranging from a minor aggravation of current condition to serious conditions such as cerebral vascular accidents. I also understand that the doctor is not liable for any problems that might arise if I decide not to follow the treatment in which he prescribes. I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to chiropractic care, including but not limited to sprain and strain, fractures, dislocations, and general aggravations of inflammatory conditions. I understand that I will have an opportunity to discuss with the doctor and/or intern and/or other office personnel the nature and purpose of the chiropractic procedures I will receive. I understand that the doctor and/or intern will perform an examination in order to minimize any risk of care, however, I do not expect the doctor and/or intern to be able to anticipate and explain all risks and complications. I therefore wish to rely on the doctor and/or intern to exercise judgment during the course of the procedure which the doctor and/or intern feels at the time, based upon the facts as then known, is in my best interest.

Medicare Patients Authorization and Assignment of Benefits

I authorize payment of government benefits to Harrisburg Family Chiropractic who accepts assignment for services covered by Medicare. I also understand it is my responsibility to pay for all other services which Medicare does not cover.

CVA Signs

If during your visit you suffer from any of the following please notify the doctor or staff immediately:

- | | |
|--|---|
| 1. Sudden severe pain in the side of your head and/or neck | 6. Hearing problems |
| 2. Vision problems | 7. Disorientation or confusion |
| 3. Numbness, loss of feeling, or abnormal feeling | 8. Speech problems |
| 4. Weakness, clumsiness, or loss of strength | 9. Loss of consciousness or momentary blackouts |
| 5. Dizziness | |

I have read, or have had read to me, the above consent and reviewed the information herein and represent that the same is true, correct and complete. I understand that the doctor is relying upon the information in rendering treatment. By signing below, I agree to the procedures. I intend this consent form to cover the entire course of care for my present condition(s) and for any future condition(s) for which I seek care.

Privacy Policy (HIPPA)

I acknowledge that Harrisburg Family Chiropractic's "Notice of Privacy Policies" has been provided to me. I understand that I have the right to review the Privacy Policy prior to signing this document. The Privacy Policy describes my rights with respect to my protected health information which is used for treatment, the payment of bills, and in the performance of health care operations of Harrisburg Family Chiropractic Clinic. Harrisburg Family Chiropractic reserves the right to change the privacy practices that are described in the "Notice of Privacy Policies". I understand that I may obtain a revised copy of the policies by calling the office and requesting a copy or by asking for one at the time of my next appointment.

Signature: _____

Date: _____

Relationship to Patient: _____