Hartland Family CHIROPRACTIC

Pediatric Intake Form

Please take a moment to answer the following questions that are designed to maximize your child's health. Many types of stress (physical, mental, and chemical) can interfere with your child's growing spine and nervous system. Spinal health is an exciting new concept for many people, so please ask questions.

Date: _____________

Patient Information

Child's Name: Date of Birth: Age:

Father's Name: Home Phone#: Cell#:

Mother's Name: Home Phone#: Cell#:

Address:

Email:

How did you hear about us?

Who is your child's primary care physician?

May we have your permission to update your medical doctor regarding your child's care at this office? ☐ Yes ☐ No

Current Health Conditions

What health condition(s) bring your child to be evaluated by a chiropractor?

When did the condition first begin? How did the problem start? ☐Suddenly ☐Gradually ☐Post-Injury

Has your child ever received care for this condition before? ☐Yes ☐No
-If yes, please explain:

Is this condition: ☐Getting worse ☐Improving ☐Intermittent ☐Constant ☐Unsure
-Please explain:

Describe the condition: ☐Aching ☐Burning ☐Dull ☐Pulling ☐Sharp ☐Shooting ☐Stabbing ☐Stinging ☐Throbbing

Does the pain/stiffness/discomfort radiate to other areas? ☐Yes ☐No
-If yes, where to?

What makes the problem better?

What makes the problem worse?

Please list any drugs, medications, herbs, etc. that your child is taking: ____________________

What would you like to gain from chiropractic care? ☐Resolve Existing Condition ☐Overall Wellness ☐Both

History

Has your child ever visited a chiropractor? ☐Yes ☐No If yes, what is his/her name?

According to the National Safety Council, approximately 50% of infant fall headfirst from a high place (bed, changing table, etc.) during the first year of life. Has this happened to your child? ☐Yes ☐No If so, please explain briefly.

Is your child receiving care from any other health professionals? ☐Yes ☐No
-If yes, please name them and their specialty:

How many prescriptions of antibiotics has your child taken: During the past 6 months: Total in his/her life:

Has your child been fully vaccinated? ☐Yes ☐No

Has your child experienced any adverse reactions to the vaccines? ☐Yes ☐No

If so, has the reaction been reported? □Yes □No
Please list all reactions of your child and other family members:
Please list all sports and activities that your child participates in:

Please check **ALL** of the following which your child has suffered from in the last 6 months.						**Family History** Mark **ALL** conditions that run in your family		**Relationship** (Father, Mother, Sister, Brother)
□	Ear Infection	□	Scoliosis	□	Anemia	□	Anemia	
□	Asthma/Allergies	□	Back Pain	□	Cancer/Tumor	□	Cancer	
□	Cold/Flu	□	Neck Pain	□	Fainting	□	Diabetes □Type 1 or □Type II	
□	Fevers	□	Growing Pains	□	Bed Wetting	□	Heart Problems/Stroke	
□	Acid Reflux	□	Seizures	□	Temper Tantrums	□	High Blood Pressure	
□	Colic	□	Convulsions	□	Hyperactivity	□	Genetic Disorders	
□	Digestive Problems	□	Headaches	□	Accident/Injuries	□	Rheumatoid Arthritis	
□	Poor Appetite	□	Dizziness	□	Ruptures/Hernias	□	Headaches	
□	Diabetes □Type 1 or □Type II	□	Other (List):			□	Other (List):	

Prenatal/Birth

Child's Birth Weight: lbs oz. Child's Birth Height: in.

Type of birth: □Normal Vaginal □Cesarean

Please check any applicable interventions or complications:
□Breech □Induction □Pain Meds □Epidural □Episiotomy □Vacuum Extraction □Forceps

Location: □Hospital □Birthing Center □Home

Describe any problems during pregnancy:

Describe any problems during delivery:

Jaundice? □Yes □No

Obstetrician/Physician/Midwife:

Consent to Treat Minor Patient without Parent Present

In order for us to treat a minor without a parent/legal guardian present, please complete this form and return it to Dr. Hans Halaska at Hartland Family Chiropractic, LLC.

I, ____________________________ (print name here) am the parent/legal guardian of ____________________________ (print name of minor), currently a minor, whose date of birth is ________________.

I authorize Dr. Hans Halaska at Hartland Family Chiropractic, LLC to provide chiropractic care to my son/daughter, including, but not limited to, diagnostic examinations (including surface EMG, thermal scanning, and x-ray), treatment procedures (chiropractic adjustment, muscle stimulation, traction, massage) as deemed appropriate by his/her chiropractor. I understand that, should my minor child need more diagnostics, attempts will be made to contact me before such care is initiated. I further understand that, once my child reaches the age of majority, my consent for treatment is no longer required. This consent will remain in effect until the patient reaches the age of eighteen unless revoked in writing to Dr. Hans Halaska at Hartland Family Chiropractic, LLC. By signing this, I acknowledge I have read and agree to this consent and that any questions I had prior to signing were answered by Dr. Hans Halaska at Hartland Family Chiropractic, LLC. Payment is expected the day of the appointment and can be made by cash, check, or credit card when checking out or in advance over the phone.

____________________________ ____________________
Signature of Parent/Legal Guardian Date

INFORMED CONSENT

Hartland Family Chiropractic LLC
Dr. Hans J. Halaska
211 Cottonwood Avenue Suite A
Hartland, WI 53029
Ph: (262)367-7424
Fax: (262)369-1068

PATIENT NAME ____

I will use my hands or a mechanical instrument upon your body in such a way as to move your joints. This procedure is referred to as "Spinal Manipulation" or "Spinal Adjustment" As the joints in your spine are moved, you may experience a "pop" as part of the process.

There are certain complications that can occur as a result of a spinal manipulation. These complications include, but are not limited to: muscle strain, cervical myelopathy, disc and vertebral injury, fractures, strains and dislocations, Bernard-Horner's Syndrome (also known as oculosympathethetic palsy), costovertebral strains and separation. Rare complications include, but are not limited to stroke. The most common complication or complaint following spinal manipulation is an ache or stiffness at the site of adjustment.

I am aware of these complications, and in order to minimize their occurrence I will take precautions. These precautions include, but are not limited to my taking a detailed clinical history of you and examining you for any defect which would cause a complication. This examination may include the use of x-rays. The use of x-ray equipment may pose a risk if you are pregnant. If you are pregnant, you should tell me when I take your clinical history.

DATE ______________________________

____
Printed Name

____
Signature

____
Signature of Parent or Guardian (if a minor)

Dr Hans J. Halaska, 211 Cottonwood Avenue, Suite A Hartland WI, 53029
262-367-7424 ~ Fax: 262-369-1068
www.hartlandchiro.com

Patient Acknowledgement and Receipt of Notice of Privacy Practices Pursuant to HIPAA and Consent for Use of Health Information

Name________________________________ Date_______________ Print Patient's Name

The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant To HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request.

The undersign does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State law and Federal Law.

Dated this _______ day of _______________________, 20___

By___________________________________
Patient's Signature

If patient is a minor or under a guardianship order as defined by State law:

By____________________________________
Signature of Parent/Guardian (circle one)