Account # _____
(for office use only)

PEDIATRIC INFORMATION

FAMILYFIRST CHIROPRACTIC

Child's Name: _____ Date:_____

Address | City | State |Zip Code: _____

Email: _____

DOB: _____ Height: _____ Weight: _____

☐ Male ☐ Female Preferred Pronoun: _____ Siblings:_____

Parent's Name: _____Phone:_____Occupation:_____

Parent's Name: _____Phone:_____Occupation:_____

Emergency Contact Name | Relationship | Phone: _____

Has your child had Chiropractic Care before? Y / N Date of last Adjustment: _____

Who may we thank for referring you to our practice? _____

REASON FOR SEEKING CHIROPRACTIC CARE

☐ Wellness Check Up

☐ Optimal Nervous System Development

☐ To relieve symptoms - (please mark areas on the diagram to the right)

☐ Other: _____

Current Health Concern:

_____

_____

_____

How long has your child been suffering from this?

_____ Days | Weeks | Months | Years

How do you think this began?

_____

What have you done to make it better?

_____

What makes it worse?

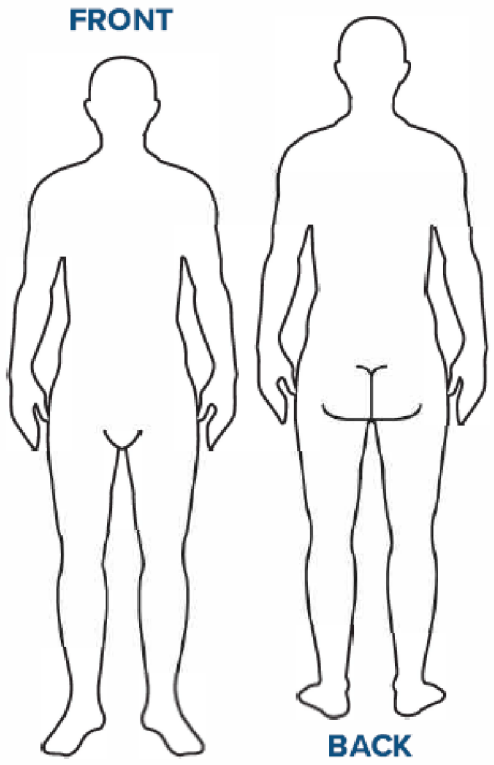
_____

What is the severity of these concerns?

1 2 3 4 5 6 7 8 9 10

How often does your child experience these concerns?

☐ Constantly ☐ Frequently ☐ Occasionally ☐ Intermittently



KEY:

X Numb/Tingling
^ Ache/Dull/Stiff
O Burning
– Swelling
> Sharp

PEDIATRIC INFORMATION

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Name: _____ DOB: _____ Account # _____
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THE BODY'S INABILITY TO EXPRESS HEALTH FULLY

The following can contribute to the nerve interference process.
Please check any that apply to your child's health history.

PHYSICAL STRESS

- ☐ Birth Trauma
- ☐ Surgeries
- ☐ Injuries
- ☐ Screen Time
- ☐ Poor Posture

EMOTIONAL STRESS

- ☐ Sensory Processing
- ☐ Overwhelm
- ☐ Quick Temper
- ☐ Anxiety
- ☐ Depression

CHEMICAL STRESS

- ☐ Formula
- ☐ Processed Food
- ☐ Sugar
- ☐ Antibiotics / Medications
- ☐ Vaccines

ALLERGIES

_____
_____
_____
_____
_____
_____

MEDICATIONS / PURPOSE

_____
_____
_____
_____
_____
_____

SUPPLEMENTS

_____
_____
_____
_____
_____
_____

Growth & Development History

Breatsfed: _____weeks _____months - Bottle Fed: _____weeks _____months

Any difficulty with breastfeeding? Y / N If yes, please explain: _____

Did they ever use formula / donor milk? Y / N _____weeks _____months

Type: _____

Number of hours of sleep at night: _____ Quality of sleep: ☐ Good ☐ Fair ☐ Poor

At what age did your child: Respond to sound _____ Hold head up _____ Crawl _____

Sit unsupported _____ Stand _____ Walk unsupported_____

Has your child ever been diagnosed with a Tongue Tie, Lip Tie or Cheek Tie? Y / N

Does your child have any sensory processing / neurodevelopmental disorders? Y / N

If yes, please explain: _____

_____

PEDIATRIC INFORMATION

FAMILYFIRST CHIROPRACTIC

Name: _____ DOB: _____ Account # _____
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Injury, Illness & Vaccination History

Please list your child's emergency, hospitalization and surgical history (include year):

_____

_____

Please list any major injuries, accidents, falls, fractures your child has sustained in their lifetime (include year):

_____

_____

Has your child received any antibiotics or other medications? Y / N

Have you chosen to vaccinate your child? Y / N ☐ Exemption ☐ Delayed ☐ Not vaccinated at this time

☐ Standard Schedule ☐ Would like more information

If yes, please list any vaccination reactions: _____

_____

Parent Pregnancy & Fertility History

Any fertility issues? Y / N If yes, please explain: _____

Did mother: ☐ Smoke ☐ Drink Alcohol ☐ Recreational Drugs ☐ Prescription Drugs ☐ Excercise

If yes, please explain: _____

Any problems during pregnancy? ☐ Gestational diabetes ☐ Pre/eclampsia ☐ Strep B ☐ Preterm labor

☐ Nausea / Vomiting ☐ Swelling ☐ Back Pain

If yes, please explain: _____

Any ultrasounds? Y / N If yes, please explain: _____

Please explain any notable episodes of physical, chemical or mental stress during pregnancy:

_____

Please explain any other concerns or notable remarks about your child's conception or pregnancy:

_____

PEDIATRIC INFORMATION

FAMILYFIRST CHIROPRACTIC

Name: _____ DOB: _____ Account # _____
(for office use only)

Labor & Delivery

Third Trimester Presentation: ☐ Vertex (head down) ☐ Posterior ☐ Breech ☐ Transverse ☐ Face/Brow

Other: _____

Location of Birth: ☐ Home ☐ Birthing Center ☐ Hospital ☐ Other: _____

Type of Birth: ☐ Vaginal ☐ Scheduled C-Section ☐ Emergency C-Section

Birth Weight: _____ Birth Height: _____ APGAR Score at 1 min_____ 5 Min_____

Obstetrician / Midwife's Name: _____

Child's Pediatrician / Family MD Name: _____

Any interventions / complications? ☐ Induction ☐ Epidural / Pain Medications / Antibiotics ☐ Forceps

☐ Suction / Vacuum ☐ Episiotomy ☐ Respiratory Distress ☐ Meconium ☐ Failure to Thrive

☐ Other: _____

Please describe any other concerns or notable remarks about your child's labor and / or delivery:

_____

What are your HEALTH GOALS for your child?

1. _____
2. _____
3. _____

What is your level of commitment to the health and well-being of your family?

1 2 3 4 5 6 7 8 9 10

Parent / Guardian Signature: _____ Date:_____

Print Name: _____ Relationship to Patient:_____

Account # _____
(for office use only)

FAMILYFIRST CHIROPRACTIC

ELECTRONIC HEALTH RECORDS INTAKE FORM

In compliance with requirements for the government EHR incentive program.

First Name: _____Last Name: _____

Preferred Language: _____DOB:_____/_____/_____

Sex:_____ Sex at Birth:_____

Smoking Status (Circle One): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked CMS requires providers to report both race and ethnicity. If yes, start date: _____

Race (Circle One): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) / Native Hawaiian or Pacific Islander / Other / Decline to Answer

Ethnicity (Circle One): Hispanic or Latino / Not Hispanic or Latino / Decline to Answer

☐ I choose to decline receipt of my clinical summary after every visit.

Parent / Guardian Signature: _____Date:_____

Print Name: _____Relationship to Patient:_____

FOR OFFICE USE ONLY

Height: _____ Weight: _____ Blood Pressure: _____/_____ Pulse: _____

FINANCIAL POLICIES

FAMILYFIRST CHIROPRACTIC

Name: _____DOB: _____ Account # _____
(for office use only)

PROOF OF INSURANCE: New patients must complete our new patient information forms before seeing a doctor. We must obtain a copy of your picture ID and current insurance card to have proof of insurance. If you do not provide us with the correct insurance information in a timely manner, you will be responsible for any balance accrued. If your insurance lapses or expires we require full payment within 10 days unless you provide proof of valid insurance coverage.

☐ SELF-PAY

Patients without health coverage are expected to make payment in full at the time services are rendered. Any Plan Discounts can only be applied to services paid at the time the services/plans are rendered/initiated. A service charge of 15.00% per annum may be applied to all unpaid balances over sixty days. Financial Hardship is only available upon proof of said hardship and exclusively at the discretion of the doctor.

☐ MEDICARE

Deductible and/or Co-Insurance is due at time of service when no secondary insurance coverage is available, or benefits cannot be verified. Services not statutorily covered by the Medicare Program are due at the time services are rendered. An Advance Beneficiary Notice will be required for all services not covered or not believed to be covered. Deductibles will be billed and shall be due within ten days. A service charge of 15.00% per annum may be applied to all unpaid balances over sixty days.

In-network plans: I understand Family First Chiropractic will submit claims on by behalf and prepare any necessary reports and forms to assist me in making collection from the insurance company. Family First Chiropractic will accept direct assignment of benefits under this policy and will credit any payments received from insurance company to your account.

NO CALL / NO SHOW POLICY

As a courtesy, please remember to call us as soon as you know that you are unable to make your scheduled appointment, and we'd be happy to rebook it for you.

I understand that if I no call no show to an adjustment appointment, my card will be ran automatically for $10.00. If I no call no show to a Review / Consult appointment my card will be ran for $25.00.
Please Initial _____

I have read and understand the above Financial Policy fully understand that I am ultimately responsible for payment of all services and any costs associated with the collections including but not limited to service charges and other fees for any balance due at to the above office and doctor.

Parent / Guardian Signature: _____Date:_____

Print Name: _____Relationship to Patient:_____

CONSENT FOR CARE

FAMILYFIRST CHIROPRACTIC

Name: _____DOB: _____ Account # _____
(for office use only)

The process of determining suitability of Chiropractic Services involves answering fully and truthfully all questions presented to you either written or spoken regarding your past and present health conditions during the Consultation.

If warranted, a physical examination will be performed that can include but is not limited to: vitals measurement, systems evaluation, orthopedic tests and maneuvers (tests that move and stress joints of the body), neurological test (tests using sharp or dull instruments, smells or sounds, gently tapping tendons) as well as physical touching. These test and maneuvers will help the Chiropractor determine what may be causing your complaints.
Occasionally some temporary soreness and/or stiffness may occur due to the examination; less frequently aggravation of presenting symptoms or initiation of new symptoms.
Radiographs (X Rays) may be taken or ordered to further the Chiropractor's understanding of the underlying condition, positions and alignment of the spine and associated structures. There is limited but present risk to radiation exposure. If you are or think you may be pregnant alert the Chiropractor and/or X ray lab technician; X Rays are not allowed to pregnant women in any trimester.

PRIVACY NOTICE ACKNOWLEDGEMENT

We are concerned with protecting your privacy, especially in matters that concern your personal health information. In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), we are required to supply you with a copy of our privacy policies and procedures. We encourage you to read this document carefully, for it outlines the use and limitations of the disclosure of your health information and your rights as a patient. If you ever have any questions or concerns regarding the use or dissemination of your personal health information, we would be happy to address them.

I consent to the performance of the above-mentioned procedures performed by the doctor involved in my case:
_____ YES _____ NO

I acknowledge that I have been offered a copy of Family First Chiropractic's Notice of Privacy Practices for Protected Health Information.

Parent / Guardian Signature: _____Date:_____

Print Name: _____Relationship to Patient:_____

Account #: _____

BIOSTRUCTURAL EXAM Visualization, Instrumentation, Static Palpation, Motion Palpation

Patient Name: _____ Date: _____ DOB: _____

GENERAL	
Dom Hand	Right/Left
Demeanor	
BP	
Pulse (bpm)/Heart	/
Respiration (bpm)/Lungs	/
Height	
Weight	

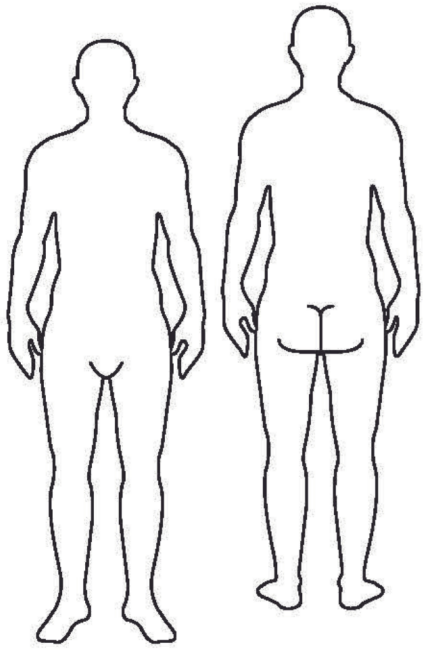
REFLEXES	LEFT	RIGHT
Biceps	1 2 3	1 2 3
Brachio	1 2 3	1 2 3
Triceps	1 2 3	1 2 3
Patellar	1 2 3	1 2 3
Achilles	1 2 3	1 2 3
Babinski	tdg / abn	tdg / abn
Ankle Clonus	+ -	+ -

ORTHOPEDIC TEST		
CervComp (neutral)		L R neck-lp Ct UEx
CervComp (L) (R)		L R neck-lp Ct UEx
Distraction		L R neck-lp Ct UEx
L Shldr Depr		neck-lp Ct UEx
R Shldr Depr		neck-lp Ct UEx
Linders		+ -
O'Donahue's		Passive Active
Antalgia		
Kemps		L R LB-lp Ct LEx
Adams		
Romberg		

CERVICAL	N	ROM	PAIN
Flexion (60)		1 2 3 4	1 2 3
Extension (55)		1 2 3 4	1 2 3
L Lat Flextion (45)		1 2 3 4	1 2 3
R Lat Flextion (45)		1 2 3 4	1 2 3
L Rotation (80)		1 2 3 4	1 2 3
R Rotation (80)		1 2 3 4	1 2 3
LUMBO-DORSAL	**N**	**ROM**	**PAIN**
Flexion (70)		1 2 3 4	1 2 3
Extension (30)		1 2 3 4	1 2 3
L LatFlex (30)		1 2 3 4	1 2 3
R LatFlex (30)		1 2 3 4	1 2 3
L Rotation (30)		1 2 3 4	1 2 3
R Rotation (30)		1 2 3 4	1 2 3

DERM	LEFT	RIGHT
C5		
C6		
C7		
C8		
T1		
T2		
L1		
L2		
L3		
L4		
L5		
S1		

SQUAT TEST	HINGE TEST
5 4 3 2 1	5 4 3 2 1



MUSCLES TESTS	LEFT	RIGHT
C5 (deltoid)	5 4 3 2 1	5 4 3 2 1
C6 (bicep)	5 4 3 2 1	5 4 3 2 1
C7 (tricep)	5 4 3 2 1	5 4 3 2 1
C8	5 4 3 2 1	5 4 3 2 1
T1	5 4 3 2 1	5 4 3 2 1
L1-3 (hip flx)	5 4 3 2 1	5 4 3 2 1
L4	5 4 3 2 1	5 4 3 2 1
L5	5 4 3 2 1	5 4 3 2 1
S1	5 4 3 2 1	5 4 3 2 1
Bilat Weight		

CRANIAL NERVES		
I	Smell	
II	Vision	
III, IV, VI	Eye mvt	
V	Jaw/Sen.	
VII	Facial mvt	
VIII	Hearing	
IX	Gag/Taste	
X	Swallow	
XI	Shrug	
XII	Tongue Mov	

EDEMA T/P Restrictions			
Occiput L/R	☐	☐	☐
C-1L/R	☐	☐	☐
C2	☐	☐	☐
C3	☐	☐	☐
C4	☐	☐	☐
C5	☐	☐	☐
C6	☐	☐	☐
C7	☐	☐	☐

EDEMA T/P Restrictions			
T1	☐	☐	☐
T2	☐	☐	☐
T3	☐	☐	☐
T4	☐	☐	☐
T5	☐	☐	☐
T6	☐	☐	☐
T7	☐	☐	☐
T8	☐	☐	☐
T9	☐	☐	☐
T10	☐	☐	☐
T11	☐	☐	☐
T12	☐	☐	☐

EDEMA T/P Restrictions			
L1	☐	☐	☐
L2	☐	☐	☐
L3	☐	☐	☐
L4	☐	☐	☐
L5	☐	☐	☐

KEY FOR ROM
ROM
☐1=76-96% ☐2=51-75% ☐3=26-50% ☐4=25%
PAIN
☐1=Mild ☐2=Moderate ☐3=Severe

PRILL TEST
Prone
Cer. Synd.
Vert.
Rad.
Med.
Lat.
LC
DEREFIELD
+DL +DR
-DL -DR
SACRUM
ADDITIONAL FINDINGS

DEGENERATION PHASE/CURVE	
Cervical	I II III /
Thoracic	I II III /
Lumbar	I II III /
LISTINGS	
C1	
C2	
C3	
C4	
C5	

CONSULTATION NOTES

Patient Name: _____ Date: _____ DOB: _____

CHIEF COMPLIANT:

Onset _____

Provoc _____

Pallative _____

Quality _____

Referred _____

Stress _____

Time _____

Associated _____

PATIENT INFORMATION:

MVAs _____

Work _____

Sports _____

Children/Pregnancy _____

Misc _____