GATEWAYS CHIROPRACTIC

PEDIATRIC INTAKE FORM

Account #:_____

Child's Name:_____ Date of Birth:_____ Age:___ Today's Date:_____

Parent(s) Name(s):_____

Address:_____ City:_____ State:_____ Zip:_____

Home Phone #:_____ Cell:_____ Email:_____

Sex: ❑M ❑F Names & Ages of Siblings:_____

Emergency Contact:_____ Relationship:_____ Phone #:_____

How did you hear about us?_____

Whom may we thank for your referral?_____

Has your child seen a chiropractor before? ❑Yes ❑No Office:_____ Last visit?_____

Reason for Care:_____ Results:_____

Whom is on your child's healthcare team? (OB, Midwife, Pediatrician, other healthcare providers)_____

_____

HEALTH PROFILE

What is the reason your child is seeking services here? ❑ Wellness ❑ Other (please describe symptoms):

_____

_____

When did these symptom(s) appear:_____

Has your child been treated for this symptom(s) on an emergency basis? ❑No ❑Yes:_____

Please list any other health concerns your child may be experiencing:_____

_____

What changes in your child's health or behavior would you like to see?_____

_____

Has your child had any surgeries, hospitalizations, or medical diagnoses?_____

_____

Any nutritional or digestive concerns?_____

_____

Please list any vitamins or supplements your child takes:_____

Please list any medications (prescription or over-the-counter) your child is using or has recently used:

Name of Medication	Dosage	Frequency	Reason for Taking

INTERNAL USE ONLY

GATEWAYS CHIROPRACTIC

Patient's Name _____ Date of Birth _____

PREGNANCY AND LABOR OF YOUR CHILD

PREGNANCY Duration of pregnancy:_____

❑ Back/Other pain ❑ Gestational Diabetes ❑ Pre/Eclampsia ❑ Step B ❑ Nausea/Vomiting
❑ Pre-Term ❑ Fatigue ❑ Swelling ❑ Other:_____

LABOR & BIRTH Duration of labor:_____

Type of birth (check all that apply)

❑ Hospital ❑ Home ❑ Birthing Center
❑ OB/GYN ❑ Midwife ❑ Doula
❑ Normal/Vaginal ❑ Breech ❑ Scheduled/Induced ❑ Epidural ❑VBAC
❑ Cesarean ❑ Forceps ❑ Vacuum Extraction

Problems during labor/delivery:

❑ Antibiotics ❑ Congenital Anomalies ❑Meconium ❑Failure to thrive ❑Respiratory Distress
❑ Jaundice ❑ Extended hospitalization ❑Other:_____
❑ Birth trauma:_____

Post-birth

❑Incubation ❑Silver nitrate drops in eyes ❑Vitamin K Shot ❑Hepatitis B Shot

GROWTH AND DEVELOPMENT

Infant feedings: ❑ Breast ❑ Bottle ❑ Formula If breastfed, for how long? _____
Any traumas or falls resulting in bruises, fractures, stitches? ❑No ❑Yes Explain:_____
Did your child receive any vaccinations? ❑Yes ❑No ❑Alternative Schedule Any poor response?_____
Do you consider their sleeping pattern normal? ❑Yes ❑No Explain:_____
Behavioral or social problems? ❑No ❑Yes Explain:_____
Does your child consume: ❑Caffeine ❑Soda ❑Sugar ❑Artificial Sweetener ❑Fast Food ❑Processed Food
Average hours of screen-time each week (television, computer, tablet, electronic games, etc.):_____
Please list any sports participation and age began (include # hours/week):_____

Has your child experience any of the following?

❑ ADD/ADHD ❑ Breathing problems ❑ Delayed Speech ❑ Hypertension
❑ Autism Spectrum ❑ Broken bones ❑ Diabetes ❑ Paralysis
❑ Anemia ❑ Chronic ear aches/infections ❑ Diarrhea ❑ Juvenile Rheumatoid Arthritis
❑ Arm problems ❑ Colds/Flus ❑ Dizziness ❑ Joint problems
❑ Asthma ❑ Colic ❑ Fainting ❑ Leg problems
❑ Backaches ❑ Constipation ❑ Headaches ❑ Neck problems
❑ Bed wetting ❑ Convulsions/Seizures ❑ Heart trouble ❑ Ruptures/hernias
❑ Allergies_____ ❑ Orthopedic problems_____
❑ Behavioral problems_____ ❑ Appetite/Eating problems_____
❑ Skin problems_____ ❑ Other:_____

_____ _____
Parent/Guardian Signature Date

GATEWAYS CHIROPRACTIC

GOALS AND EXPECTATIONS

Patient's Name _____ Date of Birth _____

We offer several types of holistic, natural healthcare at our office. Please mark which types of care you are interested in:

- ❑ **Chiropractic Care** – spinal-specific adjustments to address structural stress and nervous system health
- ❑ **Acupuncture** – the use of needles, gentle electric stimulation, or both, to assist with the balance and circulation of energy in the body; commonly used to alleviate pain and assist in treating numerous conditions
- ❑ **Nutritional Coaching & Digestive Health Consultation** – this may include a full functional health examination and the recommendation of enzyme nutrition, nutritional changes, lifestyle changes, and other supplementation.
- ❑ **Unsure** – I would like the doctor to select the type of care that is most appropriate for my condition

People visit a chiropractor for a variety of reasons. In order to better serve you, we'd like to know which of the following healthcare options you are most interested in and intend to follow:

- ❑ **Preventive Care** – wellness and life-enhancement care (pro-active health empowerment)
- ❑ **Maintenance Care** – removing symptoms and their cause with periodic routine maintenance
- ❑ **Relief Care** – remove acute symptoms only; short-term relief
- ❑ **Unsure** – I would like the doctor to select the type of care that is most appropriate for my condition

CONSENT

I authorize the doctors at Gateways Chiropractic and whomever they may designate as their assistants to administer treatments as the doctor(s) deem necessary to _____ (name of patient).

I authorize the doctors at Gateways Chiropractic to a complete chiropractic & functional health examination and any further testing (urinalysis, blood work, radiographs) that the doctor deems necessary.

_____ _____
Printed name of person authorizing treatment Date

_____ _____
Signature Relationship to Patient

OFFICE POLICIES

Accepting New Patients – the doctors at Gateways Chiropractic reserve the right to accept or decline any case or new potential patient at the office.

Lengthy or Confidential Questions – if you have any lengthy or confidential questions to discuss with the doctor, we will be happy to have the doctor call you or arrange a special appointment for a private consultation.

Missed Appointments – if for any reason you must miss your scheduled appointment, please call as soon as possible so that your appointment may be rescheduled so that your health goals can be reached. If you miss your appointment and do not call that day, Gateways Chiropractic reserves the right to charge a fee of $25 to your account at the end of that business day.

Cell Phone Policy – To ensure a peaceful, relaxing, and healing environment, please place cellular phones and other electronic devices on vibrate or silent and refrain from cell phone use in our office.

Severe Weather – The office may close in the event of severe weather. In the case of extreme weather conditions, please call first to be sure the office is open.

I have read and understand the above policies.

_____ _____
Patient/Guardian Signature Date

GATEWAYS CHIROPRACTIC

FINANCIAL POLICY & AGREEMENT

Patient's Name _____ Date of Birth _____

Your health is our primary concern. Our recommendations are based on a desire to see you get well and stay well. We will suggest the chiropractic care and other treatments that we believe you need to reach your health goals. We ask that you read and understand our financial policy as it applies to your particular situation.

As healthcare providers, our relationships with our patients are of the utmost importance. We offer a unique perspective on health and healing that is quite different from the mainstream allopathic/medical approach. Because we focus on functional health and a preventative, holistic approach to healthcare, our core values are not aligned with those of insurance companies. For these reasons, and in an effort to provide the best possible care to our patients and to keep our prices fair and reasonable, Gateways Chiropractic, LLC is out-of-network with insurance companies (with the exception of Medicare). We are happy to provide you with the billing information you will need to submit to your insurance company for out-of-network benefits and reimbursement. We have a relationship with you, our patient, and not your insurance company. We are not responsible for, and cannot guarantee, reimbursement or payment to you by your insurance company.

In the event that you default in your financial and/or care agreement with us, the professional services being provided to you and your family will stop until all deficiency balance has been brought current. If you suspend or terminate care as prescribed by the doctors at Gateways Chiropractic, LLC, any remaining balance will be due and payable immediately.

Full payment is due at the time of service. We accept cash, check, and credit cards.

MEDICARE

Medicare only covers manual manipulation of the spine for acute conditions. All other services are *NON-COVERED*. These services include, but are not limited to: examinations, therapies, acupuncture, therapeutic exercise, orthotics, supports, nutritional supplements, x-rays, and/or wellness adjustments. We *DO NOT* accept assignment from Medicare. This means that the patient is responsible for paying at the time of service.

I have read and understand the financial policy of Gateways Chiropractic, LLC. I understand that I am financially responsible for the care I receive at Gateways Chiropractic, LLC. I understand that full payment is due at the time of service (cash, check, and credit cards are accepted).

_____ _____

Patient/Guardian Signature Date

HIPAA/NOTICE OF PRIVACY PRACTICES

GATEWAYS CHIROPRACTIC
2241 Bluestone Drive, St. Charles, MO 63303 • (636) 940-2226 • www.gatewayschiropractic.com

GATEWAYS CHIROPRACTIC

Patient's Name _____ Date of Birth _____

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment, or health care operations and for other purposes that are permitted by law.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time.

SPECIFIC AUTHORIZATIONS

- I give permission to use my address, phone number, and clinical records to contact me with appointment reminders, missed appointment notifications, birthday cards, holiday cards, newsletters, and information about health-related information and Gateways Chiropractic.
- If Gateways Chiropractic contacts me by phone, I give them permission to leave a message on my answering machine/voicemail or to send me a text message.
- I give Gateways Chiropractic permission to use any testimonial written by me for promotional, educational, and informational purposes.

EXPIRATION This authorization shall expire on the following date: *ongoing*

RIGHT TO REVOKE AUTHORIZATION

You have the right to revoke this authorization, in writing, at any time. However, your written request to revoke this authorization is not effective to the extent that we have provided services or taken action in reliance on your authorization. You may revoke this authorization by mailing or hand delivering a written notice to the Privacy Official of Gateways Chiropractic, LLC. The written notice must contain the following information:

Your name, Social Security number, and date of birth;
A clear statement of your intent to revoke this authorization;
The date of your request; and
Your signature.

The revocation is not effective until it is received by the Privacy Official.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY POLICIES

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

The right to review the notice prior to signing this consent,
The right to object to the use of my health information for directory purposes, and
The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

By signing this form, you are giving Gateways Chiropractic permission to use and disclose your protected health information in accordance with the directives listed above.

_____ _____

Patient/Guardian Signature Date

GATEWAYS CHIROPRACTIC

INFORMED CONSENT

Patient's Name _____ Date of Birth _____

When a patient seeks chiropractic care, acupuncture, or other natural, holistic, or alternative healthcare, and we accept a patient for such care, it is essential for both parties to be working towards the same objective. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo care at our office.

CHIROPRACTIC is the science and art which concerns itself with the relationship between physical structure (the spine) and function (the nervous system) as that relationship may affect health. **HEALTH** is a state of optimal physical, mental, and social well-being, not only the absence of sickness, disease, or symptoms.

One disturbance to the nervous system is called a **VERTEBRAL SUBLUXATION**. This occurs when one (or more) of the 24 bones in the spine do not move properly and/or become mis-aligned. This causes alteration in nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected by a **CHIROPRACTIC ADJUSTMENT**. An adjustment is a specific application of forces to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine or other joints. Adjustments are usually done by hand but may be performed with a hand-held instrument. Adjustments may cause an audible "pop" or "click." You may feel a sense of movement.

If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another healthcare provider.

ANALYSIS/EXAMINATION/TREATMENT

As part of the analysis, examination, and treatment, you are consenting to the following procedures:

▫ chiropractic adjustments	▫ palpation	▫ vital signs
▫ range of motion testing	▫ orthopedic testing	▫ basic neurological testing
▫ muscle strength testing	▫ postural analysis	▫ electric muscle stimulation
▫ ultrasound	▫ hot/cold therapy	▫ acupuncture

RISKS

As with any healthcare procedure, there are certain risks which may arise during chiropractic adjustments and therapies. Some patients will feel some stiffness and soreness following the first few days of treatment. Other complications are rare and include but are not limited to: muscle strain, fractures, disc injuries, dislocations, and sprains. In exceedingly rare instances, with some types of manipulation of the neck, there has been an association with injuries to the arteries in the neck, contributing to serious complications including stroke. The incidences of stroke are estimated to occur between one in one million and one in five million cervical adjustments. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

I have read or have had read to me the above explanation of the chiropractic adjustment and related treatment. By signing below I state that any questions I had have been answered to my satisfaction and I have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

_____ _____

Patient/Guardian Signature Date