ZIKA 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, chemical) can interfere with your child's growing spine and nervous system. Spinal health is an exciting new concept for many people, so please remember to ask questions.

Date: _____

Child's Name_____Date of Birth_____Age_____

Father's Name_____Home Phone #_____Cell#_____

Mother's Name_____Home Phone #_____Cell#_____

1. Please **circle** appropriately: Birth place: Home/Hospital/Birth Center
   Type: Vaginal/C-Section/
   Procedures: Forceps/Vacuum Extraction
2. **Circle** if your child was: breast fed or formula fed
3. Please list all sports and activities that your child participates in:

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4. According to the National Safety Council, approximately 50% of infants fall head first from a high place (changing table, etc.) during the first year of life. Has this happened to your child?
Y/N If yes, please briefly explain:

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5. Please circle any of the following conditions that your child has suffered from in the last six months: Ear Infections Scoliosis Seizures Chronic Colds Head Aches ADHD Asthma/Allergies Digestive Problems Recurring Fevers Colic Bed Wetting Growing Pains Car Accident Other_____

6. List other doctors you have seen for the above conditions: _____

7. In the last year has your child taken or currently taking any prescription **or** over the counter Medications. Y/N If so, please list the name of the medication _____

8. How many prescriptions has your child taken:
   During the past 6 months: _____During His/Her Lifetime_____

9. Has your child been fully vaccinated? Y/N

10. Has your child experienced any adverse reactions to the vaccines? Y/N
    If so, has the reaction been reported? Y/N Please list all reactions of your child and other family members: _____

11. Please list any and all concerns you have about your child's health_____

_____

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INFORMED CONSENT

PATIENT NAME _____

Clinic Name _____

Doctor's Name _____

Address _____

Phone _____ Fax _____

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 compilations 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 oculosympathetic 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 you clinical history.

DATE _____ _____

Printed Name

_____

Signature

_____

Signature of Parent or Guardian (if a minor)

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)

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. Jacob Zika at Zika Chiropractic, PLLC.

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. Jacob Zika at Zika Chiropractic, PLLC 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. Jacob Zika at Zika Chiropractic, PLLC

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. Jacob Zika at Zika Chiropractic, PLLC.

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

Phone Numbers:

Home: _____ Work: _____

Cell: _____