PRIOUX CHIROPRACTIC

7650 ANCHOR DRIVE, PORT ARTHUR, TX 77642

Pediatric Chiropractic Intake Form

Name:____ **Date:**_______________________

Address:____

Sex: Male☐ Female☐ Date of Birth:________________ **Height:**_______ **Weight:**______

Name(s) of Parents/Guardian:____

Home Phone:__________________ **Cell Phone:**_________________ **Work Phone:**_____

Present Complaint:_____________________________ **When did this begin?**___________

Was there an accident or injury involved? Yes ☐ No ☐

Has your child had any past treatment for this complaint? Yes ☐ No☐

Describe:____

Current Medications: ____

Genetic disorders or disabilities: ____

How many times has your child been prescribed antibiotics in the past 6 months?__________

Has your child received vaccinations? Yes ☐ No ☐

If yes, is it the full graduated schedule?____________

Is/has your child ever been involved in any sports? Yes ☐ No ☐ Explain: ____________

Has your child ever been involved in a car accident? Yes ☐ No ☐ Explain: ___________

Other traumas not described above? Yes☐ No☐ Explain: ________________________

Prior Surgeries? Yes☐ No☐ Explain: ____

Diet: How is your child's diet? Well balanced☐ Average☐ High sugar/ processed foods☐

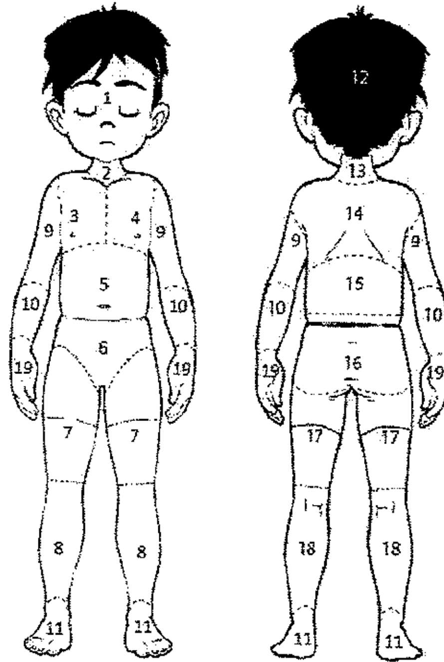
Sodas: How many cans are consumed a day? _________

Screen Time: (Tv, Gaming, IPad, ect.): how many hours a day?________

Sleep: Number of hours your child sleeps: _______ **per night** _________ **hours per day (naps)**

Past Chiropractic Care? Yes☐ No☐ Who?________________________ **When?**____________

1 – face
2 – neck
3 – left chest
4 – right chest
5 – stomach
6 – abdomen
7 – thighs
8 – legs
9 – upper arms
10 – lower arms
11 – feet
12 – back of head
13 – back of neck
14 – upper back
15 – middle back
16 – lower back
17 – back thighs
18 – back legs
19 – hands



Imagine this picture is your body. Can you color the area that is hurting you right now?

Review of Systems:

Please check if your child has had any of the following:

Headaches
Postural Imbalances
Growing Pains
Scoliosis
Sensory Processing
Asthma
Torticollis
Ear Infections
Seizures
Tonsillitis
Sleep Problems
Constipation
Bedwetting
Autism
ADD/ADHD
Frequent Fever
Colic
Learning Difficulties
Acid Reflux
Hip Dysplasia
Allergies

Informed consent:

The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or care if she is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known, or to learn through healthcare procedures, whatever he/she is suffering from - a latent pathological defect, illnesses or deformities - which would otherwise not come to the attention of the chiropractic physician.

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Authorization to Treat a Minor

I, [print name]_____________________________________, the undersigned, being the parent and/ or legal guardian of the above-referenced minor consent to and request that he/she be examined, evaluated and treated at this office within the scope of any duly licensed Doctor of Chiropractic (D.C). Services rendered may include but are not limited to, applicable x-rays, examinations, evaluation of any licensed Doctor of Chiropractic or other qualified staff of Prioux Chiropractic Center. This consent shall be valid from this date forward until this applicable medical care is resolved or withdrawn by the undersigned. If I withdraw this consent, I, the undersigned, understand that I am responsible for, and agree to pay any and all outstanding monies due for services rendered hereunder and understand that I must notify Prioux Chiropractic Center IN WRINGING of my intent to withdraw consent.

Symptom Survey

List problems from most sever to least sever. Please be as specific as possible.

Problem #1.____

Location of pain:____

Severity of pain: (no pain) 0 1 2 3 4 5 6 7 8 9 10 (worst pain imaginable) **Pain is**? Mild Moderate Severe

Progression (circle): same, better, worse. **How often is the pain present?** Constant, 50-75%, 25-50%, less than 25%

When did you notice the problem? ____________ **What happened**____________________

Better with (circle): rest ice heat stretching exercise pain relievers topical creams other __________

Worse with (circle): sitting standing walking bending twisting lifting movement other __________

Quality of pain(circle): sharp shooting dull ache burning stiff stabbing throbbing numb sore

Does your pain radiate (example: travel into arms, legs etc.) Yes or No / where? ________________

What time of day is your problem the worse (circle): morning afternoon evening during sleep

What treatment have you received for this condition: medication physical therapy surgery chiropractic

Other ______________________ **did it help**? Yes or No

Problem #2.____

Location of pain:____

Severity of pain: (no pain) 0 1 2 3 4 5 6 7 8 9 10 (worst pain imaginable) **Pain is**? Mild Moderate Severe

Progression (circle): same, better, worse. **How often is the pain present?** Constant, 50-75%, 25-50%, less than 25%

When did you notice the problem? ____________ **What happened**____________________

Better with (circle): rest ice heat stretching exercise pain relievers topical creams other __________

Worse with (circle): sitting standing walking bending twisting lifting movement other __________

Quality of pain(circle): sharp shooting dull ache burning stiff stabbing throbbing numb sore

Does your pain radiate (example: travel into arms, legs etc.) Yes or No / where? ________________

What time of day is your problem the worse (circle): morning afternoon evening during sleep

What treatment have you received for this condition: medication physical therapy surgery chiropractic

Other ______________________ **did it help**? Yes or No

Informed Consent for Chiropractic Treatment

TO THE PATIENT: You have a right to be informed about your condition, the recommended chiropractic treatment, and the potential risks involved with the recommended treatment. This information will assist you in making an informed decision whether or not to have the treatment. This information is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or refuse to give your consent to treatment.

I request and consent to chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays. The chiropractic treatment may be performed by the Doctor of Chiropractic named below and/or other licensed Doctors of Chiropractic working at this clinic or office. Chiropractic treatment may also be performed by a Doctor of Chiropractic who is serving as a backup for the Doctor of Chiropractic named below

I have had the opportunity to discuss with the Doctor of Chiropractic named below, my diagnosis, the nature and purpose of my chiropractic treatment, the risks and benefits of my chiropractic treatment, alternatives to my chiropractic treatment, and the risks and benefits of alternative treatment, including no treatment at all.

I understand that, there are some risks to chiropractic treatment including, but not limited to:

- ☐ Broken bones
- ☐ Dislocations
- ☐ Sprains/strains
- ☐ Burns or frostbite (physical therapy)
- ☐ Worsening/aggravation of spinal conditions
- ☐ Increased symptoms and pain
- ☐ No improvement of symptoms or pain
- ☐ Infection (acupuncture)
- ☐ Punctured lung (acupuncture)
- ☐ Other ______________________

In rare cases there have been reported complications of arterial dissections n (stroke) when a patient receives a cervical adjustment. The complications reported can include temporary minor dizziness, nausea, paralysis, vision loss, locked in syndrome (complete paralysis of voluntary muscles in all parts of the body except for those that control eye movement), and death.

I do not expect the doctor to be able to anticipate and explain all risks and complications. I also understand that no guarantees or promises have been made to me concerning the results expected from the treatment.

TREATMENT PLAN: ____

____

____

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions. All of my questions have been answered to my satisfaction. By signing below, I consent to the treatment plan. I intend this consent form to cover the entire course of treatment for my current condition.

To be completed by the patient:

____
print name

____
signature of patient

____
date signed

To be completed by the patient's representative:

____
print name of patient

____
print name of patient's representative

____
signature of patient's representative

as: ______________________
relationship/authority of patient's representative

____
date signed

To be completed by doctor or staff:

____
witness to patient's signature

____
date

____
translated by

____
date

PRIOUX CHIROPRACTIC CENTER
HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy describes how we may use and disclose your protected health information (PHI) to carry our treatment, payment or health care operations (TPO) for other purposes that are permitted or required by law. "Protected Health Information" is information about you, including demographic information that may identify you and that related to your past, present, or future physical or mental health or condition and related care services.

Use and Disclosures of Protected Health Information:

Your protected health information may be used and disclosed by your physician, our staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, pay your health care bills, to support the operations of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your health care information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing, and fundraising activities, and conduction or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations included as required by law, public health issues, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, and organ donation. Required uses and disclosures under the law, we must make disclosures to you when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES WILL BE MADE ONLY WITH YOUR CONSENT, AUTHORIZATION OR OPPORTUNITY TO OBJECT UNLESS REQUIRED BY LAW.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

______________________________ ____________________

Signature of Patient of Representative Date

____

Printed Name