Johnson Chiropractic &
Holistic Health Center, LLC.
Chiropractic – Acupuncture – Nutrition & Functional Medicine – Injury Rehab

Dr. Kody R. Johnson, DC, MTAA

Clinic Use: DOI: _____ INS: _____ File #: _____

Pediatric Chiropractic Intake Form (birth to 12 years)

Please note that this form is *very comprehensive* from prenatal to pre-teen. We wish to give you and your child the best care possible and believe the more details known, the more we can help you and your family live a happy and healthy life. Depending on the age of your child you may feel some sections / questions are not applicable; you may choose not to fill those sections / questions out. Should you have any questions or concerns regarding the reasons some sections / questions are on this form, please do not hesitate to contact our office.

General Information

Childs Full Name: _____ DOB: _____ SS#: _____

Mothers Name: _____ Home Phone: _____

Fathers Name: _____ Cell Phone: _____

Other Guardian & Relationship: _____ Work Phone: _____

_____ Email: _____

Mailing Address: _____ Home Address: _____

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

How did you hear about us (if referred please put their name)?

_____

Has your child seen a chiropractor before? □ No □ Yes

By whom: _____

Who is your child's primary care provider and the date of their last visit? _____

_____

Does your child see any other health care professional?

□ No □ Yes – name and specialty: _____

_____

Present Complaint and Chiropractic Goals

What brings you to our office today? _____

_____

Was it: □ Sudden □ Gradual □ Post Injury / Accident

When did this begin? _____

Has anything made it better? _____

_____

Does anything make it worse? _____

_____

Has your child been seen previously for this complaint?

□ No □ Yes – if yes, please list doctor and treatment:

_____

Are there any other health concerns? _____

_____

_____

Please list your Top 3 Goals for your child through chiropractic care:

_____

_____

_____

What would you like to gain from chiropractic?

□ Resolve existing condition

□ Overall wellness

□ Both

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VACCINATION & MEDICATION HISTORY

Please list any-and-all known medicine allergies or intolerances:

Please list any-and-all prescription or over-the-counter (OTC) medications, and supplements your child has taken within the **last 3 months**:

Please list any and all prescription or OTC medications, and supplements your child has had within the **last 4 years** (if known):

Has your child *ever* been prescribed and taken antibiotics?
□ No □ Yes – please explain why:

Has your child received vaccinations? □ No □ Yes – if yes, which schedule?

Is your child up-to-date on the chosen schedule?
□ No □ Yes

After receiving vaccinations were there any immediate (within the week) reactions?
□ No □ Yes – please describe:

After receiving vaccinations were there any noticeable physical or behavioral changes *at any time*?
□ No □ Yes – describe:

Were there any negative reactions to the antibiotics?
□ No □ Yes – please explain:

PRENATAL HISTORY

Is your child adopted? □ No □ Yes – if yes, at what age?
If adopted you may skip the remainder of the prenatal and birth history, unless you know specifics to some of the questions.

Did the mother have any complications during conception or pregnancy? □ No □ Yes – please explain:

Did the mother smoke tobacco or marijuana?
□ No □ Yes – how often or how many per week?

Did the mother take any prescription or OTC medications, or supplements during the pregnancy? □ No □ Yes – please list:

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

Did the mother have any episodes of mental or physical stress during pregnancy? □ No □ Yes – please explain:

Did the mother consume alcoholic beverages?
□ No □ Yes - how often or many per week?

Was the mother ill at any time during the pregnancy?
□ No □ Yes – please explain:

At any time did the mother have:
□ Ultrasound □ X-Rays
□ MRI □ CAT-Scans

BIRTH HISTORY

Name of Midwife and / or OB-Gyn:

At how many weeks was your child born:

Was the delivery: □ Planned □ Emergency

Place of birth: □ Home □ Birthing Center □ Hospital
□ Other:

Delivery position: □ On back □ Squatting □ Other:

Were there any complications during delivery? □ No □ Yes
If yes, explain:

Were there any genetic disorders or disabilities noted at birth?
□ No □ Yes – please list:

Birth Height: Birth Weight:

Type of Birth: □ Vaginal □ C-section

Birth intervention: □ Doctor assisted □ Forceps
□ Twisting / Pulling □ Vacuum

Was labor induced? □ No □ Yes – why:

Were there purple markings on their face? □ No □ Yes
Was the skull / head misshapen? □ No □ Yes

APGAR: □ Birth: ___ / 10 □ 5 min: ___ / 10

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FEEDING HISTORY

Please list any and all known food allergies and / or intolerances: _____

_____

_____

Was your child breast fed? □ No □ Yes – How long: _____

Were there any difficulties breastfeeding? □ No □ Yes:

Please explain: _____

Solids were introduced at: _____ months

Cow's milk was introduced at: _____ months

What fluids does your child consume the most? Of the 8 options

Below please rank them 1 – 8; 1 = most, up to 8 = least:

___ Water ___ Soda ___ Juices ___ Sports Drinks

___ Milk: □ Cow □ Almond □ Soy □ Other:_____

___ Coffee ___ Tea ___ Other: _____

Was your child formula fed? □ No □ Yes – How long: ____

What formula's: _____

How would you rate your child's diet:

□ Well balanced □ Average □ High in sugar / processed foods

Does your child crave: □ Sugar □ Salt □ Fats □ Meats □ Other

Please list the average number of times *per week* your child consumes the following different food groups:

____ Meats: □ Beef □ Poultry □ Fish □ Other

____ Dairy ____ Vegetables ____ Fruits

____ Grains ____ Legumes & Beans

____ Sugars ____ Nuts & Seeds

OTHER DEVELOPMENTAL AREAS

STAGES OF RESPONSE: AT WHAT AGE WAS YOUR CHILD ABLE TO:

_____ Respond to sound _____ Respond to visual stimuli _____ Hold head up alone _____ Vocalize – general noise

_____ Vocalize – baby talk _____ Crawl _____ Sit up alone _____ Stand-alone _____ Walk alone

SLEEP:

Sleep quality: □ Good □ Fair □ Poor Average number of hours per night: _____

Does your child still take naps? □ No □ Yes – how many and long per day: _____

Does your child have night terrors? □ No □ Yes

Does your child eat before bed? □ No □ Yes

If yes, what types of food: _____

Does your child frequently wet the bed? □ No □ Yes

Does your child drink before bed? □ No □ Yes

How many hours before? ____What type? _____

PHYSICAL ACTIVITY:

Has your child ever fallen (head first) from a high place during: (i.e.: a bed, changing table, down stairs, sofa, chair, tree, etc.)

Their first year of life? □ No □ Yes Year two onward? □ No □ Yes – year / age: _____

Is / has your child been involved in any sports? □ No □ Yes – please select:

□ Soccer □ Football □ Baseball / Softball □ Gymnastics □ Basketball □ Volleyball

□ Cheerleading □ Martial Arts □ Swimming □ Cycling □ Tennis □ Hockey

□ Track & Field □ Horseback riding □ Other: _____

SURGERIES & TRAUMAS

Has your child ever been in a car accident? □ No □ Yes: age _____

Surgeries and age: _____

Has your child ever been seen on an emergency basis?

□ No □ Yes – please explain: _____

_____ _____

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Other traumas not described above: _____

Please Circle: **Y** = A condition your child has now **N** = Never had **P** = Has had in the past – please list age					
Acid Reflux	Y N P___	Epilepsy	Y N P___	Sleeping problems	Y N P___
ADD / ADHD	Y N P___	Fainting	Y N P___	Sore Throats	Y N P___
Allergies	Y N P___	Fatigue	Y N P___	Stomach Aches	Y N P___
Anemia	Y N P___	Frequent Fever	Y N P___	Temper Tantrums	Y N P___
Arthritis	Y N P___	Growing Pains	Y N P___	Tonsillitis	Y N P___
Asthma	Y N P___	Headaches	Y N P___	Torticollis	Y N P___
Back Pain	Y N P___	Hearing Problems	Y N P___	Urinary Problems	Y N P___
Bedwetting (Excessive)	Y N P___	Heart Trouble	Y N P___	Walking Problems	Y N P___
Behavioral Problems	Y N P___	Hernias	Y N P___	Whooping Cough	Y N P___
Blood Disorders	Y N P___	Hip Dysplasia	Y N P___	Other: Please Describe:	
Broken Bones	Y N P___	Hyperactivity	Y N P___		Y N P___
Bronchitis / Upper Respiratory Infections	Y N P___	Jaundice	Y N P___		
Car Accident	Y N P___	Learning Difficulties	Y N P___		Y N P___
Chicken Pox	Y N P___	Loss of Balance	Y N P___		
Chronic Colds	Y N P___	Loss of Smell	Y N P___		Y N P___
Chronic Ear Aches	Y N P___	Mumps	Y N P___		
Colic	Y N P___	Neck Pain	Y N P___	Other Notes:	
Constipation / Diarrhea	Y N P___	PDD / Autism	Y N P___		
Convulsions	Y N P___	Poor Appetite	Y N P___		
Depression	Y N P___	Poor Coordination	Y N P___		
Diabetes	Y N P___	Postural Imbalances	Y N P___		
Digestive Problems	Y N P___	Rubella	Y N P___		
Dizziness	Y N P___	Scoliosis	Y N P___		
Ear infections	Y N P___	Shortness of Breath	Y N P___		
Eczema / Skin Problems	Y N P___	Sinus Problems	Y N P___		

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Patient Treatment Agreement Form &

Clinic Payment Policy – Out of Pocket Payment & Insurance Processing Policy

Informed Consent:

- Depending upon your condition, you will require a unique amount and type of care designed specifically for your condition. As with all healthcare types, following the prescribed treatment plan as recommended by the Doctor of Chiropractic does not constitute nor guarantee a cure.
- Chiropractic is a conservative and low risk health care choice. Most common side-effects can include some minor soreness, similar to that which is felt from exercising. A very rare side-effect is vertebrobasilar incident (VBI) or stroke from cervical adjustment. The risk is reported in the scientific literature as being *1:1 million to 1:4 million* adjustments. The likelihood of this occurring is just as common as if you were to get your hair washed at a hair-salon, or if you turn your head to look back as you back out of your driveway. Recent research shows that a visit to a Chiropractor's (D.C.) office is just as safe as a visit to an M.D.'s office in this regard. Furthermore, it has been decided that treatment does not cause VBI, rather, patients report to either an M.D. or D.C. for symptoms of a VBI without knowing they are having this syndrome in the first place since it mimics the symptoms of migraine headache or neck pain. Other possible rare complications from care include fracture, or sprain / strain of the affected body regions.
- Other common methods of treating neuromusculoskeletal problems such as taking Tylenol, Ibuprofen, Aspirin, and Naproxen have a significantly higher risk of an adverse event as compared to Chiropractic Care (*3200:1million vs. 1:1million*). Spinal surgery also possesses a significantly higher risk as compared to Chiropractic as well (*15,600:1 million vs. 1:1 million*).
- By signing this form, you are aware of and are taking responsibility for any risks or benefits, and are stating that you would like to begin care here at Our Clinic.

Consent to Privacy Practices:

- Your health information is considered to be protected and confidential. Under federal law (HIPAA), Our Clinic must keep your protected health information (PHI) confidential and can only use it within certain guidelines, which may be subject to your prior approval. Our Clinic will use your PHI in order to formulate an appropriate diagnosis and treatment plan, make any necessary referrals; collect payment from your insurance company, attorney, yourself, or any other necessary collections agency, or individual. Of course, you may limit how we use and to whom we disclose your PHI to. You must put any exceptions in writing and give to our front desk staff. By signing this form you are agreeing to our privacy practices. You are also giving our office the ability to contact you by any means necessary, including but not limited to: mail, email, telephone, fax, etc. If you would like a copy of Our Clinic's "privacy practices policy", please ask any of our staff and they will provide you with one.

Scheduling, Attendance & Payment Policy:

- Any appointment you make is reserved specifically for you. Arriving more than **five** minutes late to an appointment will result in your appointment being treated as a "walk-in", and you will be seen at the next available time.
- If you will be unable to been seen at your scheduled appointment time, you are required to call and inform Our Clinic at least **four** hours before your scheduled appointment time to cancel or reschedule. Failure to do so will result in a No-Call-No-Show, and we reserve the right to charge you the fee expected at time of service.
- Payment is expected in full at the time of service. Fees are not negotiable. Accounts that are due past 30 days will incur a $10 late fee after each 30 days. After 90 days, the amount will be turned into collections. Accounts in the collections process will accrue 15% interest per annum until collected fully. The patient is also responsible to pay court costs, attorney fees, and any other fee associated with the collections process in addition to the fees of their delinquent account. If your health insurance, car insurance, personal injury settlement, worker's compensation insurance, payment or settlement amount, attorney, or any other paying entity fails to pay Our Clinic completely for services rendered, you are still responsible to pay all of the difference due. We have no control over what your insurance

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COMPANY OR OTHER PAYING ENTITY WILL OR WILL NOT PAY, AND OUR CLINIC WILL NOT BE HELD RESPONSIBLE AS SUCH. YOUR SIGNATURE INDICATES YOUR AGREEMENT WITH THESE POLICIES AND CLAUSES.

PATIENT TREATMENT AGREEMENT FORM &

CLINIC PAYMENT POLICY - OUT OF POCKET PAYMENT & INSURANCE PROCESSING POLICY (CONTINUED)

- PAYMENT IS REQUIRED FOR YOUR AMOUNT OWED AT TIME OF SERVICE.
- OUR CLINIC WILL GLADLY SUBMIT INSURANCE CLAIMS ON YOUR BEHALF FOR SERVICES RENDERED. HOWEVER, *IN THE EVENT YOUR HEALTH INSURANCE OR OTHER PAYING ENTITY DOES NOT COVER OUR SERVICES, YOU (THE PATIENT) WILL BE REQUIRED TO PAY, IN FULL, ANY AMOUNT NOT COVERED. IT IS YOUR RESPONSIBILITY TO KNOW YOUR OWN INSURANCE BENEFITS, AND OUR CLINIC DOES NOT ASSUME RESPONSIBILITY IN THE EVENT WE ARE GIVEN INCORRECT INSURANCE BENEFIT QUOTES* FROM AN INSURANCE COMPANY. THE ACT OF OUR OFFICE LOOKING UP HEALTH INSURANCE BENEFITS IS A COURTESY TO YOU, OUR PATIENT, BUT IS NOT A REQUIREMENT.
- IF YOU (THE PATIENT) ARE MEETING YOUR DEDUCTIBLE ON YOUR INSURANCE PLAN, YOU WILL BE ASKED TO PAY THE FULL AMOUNT OF YOUR VISIT AT THE TIME OF SERVICE. IF WE ARE EVER IN DOUBT OF THE DEGREE OF INSURANCE COVERAGE PRESENT, YOU (THE PATIENT) WILL BE REQUIRED TO PAY THE FULL AMOUNT DUE ON THE SAME DATE OF SERVICE.
- IF YOUR INSURANCE CLAIM IS DENIED, YOU WILL BE ASKED TO PAY THE OUTSTANDING BALANCE ON YOUR ACCOUNT. IF YOU BELIEVE THE SERVICES SHOULD HAVE BEEN APPROVED AND PAID FOR BY YOUR INSURANCE YOU MAY REQUEST THAT WE RESUBMIT YOUR CLAIM(S). IF CLAIMS ARE RESUBMITTED AND APPROVED BY YOUR INSURANCE YOU WILL BE REIMBURSED OR CREDITED BACK FUNDS, IF AND WHEN THOSE DATE(S) OF SERVICE ARE PAID FOR BY YOUR INSURANCE.
- IN NO INSTANCE SHALL OUR CLINIC EVER BE REQUIRED TO RESUBMIT A PREVIOUSLY DENIED CLAIM IF WE EXPECT THE RESUBMITTED CLAIM WILL ALSO BE DENIED.
- WE ARE IN-NETWORK AND / OR ARE PARTICIPATING PROVIDERS WITH MOST, BUT NOT ALL INSURANCE PLANS. BEING AN IN-NETWORK / PARTICIPATING PROVIDER MEANS THAT WE WILL ACCEPT THE CONTRACTED AMOUNT ON CONTRACTED COVERED SERVICES AS PAYMENT IN FULL IN ADDITION TO ANY REQUIRED COPAYS / COINSURANCE PAYMENTS. HOWEVER, IN THE EVENT A SERVICE IS NOT COVERED OR IS NOT A CONTRACTED SERVICE, YOU (THE PATIENT) ARE OBLIGATED TO PAY OUR CLINIC IN FULL FOR SERVICES RENDERED AT OUR CLINIC'S TYPICAL FEE SCHEDULE. IF INSURANCE IS BILLED AND DOES NOT PAY FOR SERVICES RENDERED, YOU (THE PATIENT) WILL BE REQUIRED TO PAY THE AMOUNT OUTSTANDING THAT WAS BILLED TO INSURANCE.
- FOR PATIENTS WITH **MEDICARE** COVERAGE, ONLY EIGHTY PERCENT (80%) OF MEDICALLY NECESSARY CHIROPRACTIC SPINAL ADJUSTMENTS ARE REIMBURSED *AFTER MEETING YOUR MEDICARE DEDUCTIBLE*. ALL OTHER CLINIC SERVICES MUST BE PAID FOR OUT OF POCKET. IF YOU ARE A MEDICARE PATIENT WITH A SECONDARY INSURANCE, THERE IS NO GUARANTEE THE SECONDARY INSURANCE WILL COVER THESE OTHER SERVICES; IF NONPAYMENT BY THE INSURANCE COMPANY(S) SHOULD OCCUR IT IS YOUR (THE PATIENT'S) RESPONSIBILITY FOR THE REMAINING AMOUNT. IF MEDICARE DOES NOT FORWARD A CLAIM TO YOUR SECONDARY, IT IS YOUR (THE PATIENT'S) RESPONSIBILITY TO CONTACT MEDICARE TO ENSURE THAT THE CLAIM IS FORWARDED.

Authorization to Treat a Minor

I, _____ the undersigned parent / guardian having legal custody / guardianship of _____, a minor, do hereby authorize, request and direct Dr. Johnson and whomever they may designate as assistant to perform in judgment any examination and chiropractic diagnosis or treatment which is deemed necessary.

Any specific written authorization you provide may be revoked at any time by writing to us at the address provided at the bottom of this form.

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Patient: _____ Signature: _____

Print Name Parent / Legal Guardian

Date: _____

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