5456 BETHELVIEW RD STE 103B CUMMING, GA 30040 | P (770) 406-8208| F (770) 406-8204
www.arisefamilychiropractic.com

ARISE
FAMILY CHIROPRACTIC

HRN: _____

PEDIATRIC INTAKE PAPERWORK

HELLO AND WELCOME TO ARISE!

Who may we thank for referring you / how did you hear about us? _____

Has your child received chiropractic care in the past? ❑ No ❑ Yes, as an ❑ Infant ❑ Child ❑ Teen

From whom did your child receive chiropractic care? _____ ❑ N/A

Please fill out the following information completely and to the best of your ability.
Remember to initial the bottom of each page.

PERSONAL INFORMATION

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

Child's Preferred Name: _____ Gender: ❑ Male ❑ Female

Email: _____ Marital Status: ❑ S ❑ M ❑ D ❑ W

Street Address: _____ City/State/Zip: _____

Guardian #1: _____ Relationship to Child: _____

Phone (❑ Cell ❑ Home ❑ Work) _____ Email: _____

Guardian #2: _____ Relationship to Child: _____

Phone (❑ Cell ❑ Home ❑ Work) _____ Email: _____

Who is responsible for the child's finances?
❑ Guardian #1 ❑ Guardian #2 ❑ Both

What is the relationship between #1 and #2?
❑ Married ❑ Divorced ❑ Other: _____

Siblings (Name(s)/Age(s)): _____ Child's Hobbies: _____

PRENATAL, BIRTH, & INFANCY HISTORY

If your child is above the age of 5, skip to PERSONAL HEALTH HISTORY

Birth Weight: ___lb ___oz Height: ___in At how many weeks of pregnancy was your child born? ____

Name of ❑ Doctor/ ❑ Midwife: _____ Delivery method: ❑ Vaginal ❑ C-Section ❑ VBAC

List any drugs/medications that you took during pregnancy: ❑ N/A _____

List any complications, serious illness, or health emergency that the mother experienced during the birth or pregnancy: ❑ N/A _____

PERSONAL & PAST HEALTH HISTORY

Current Weight: _____lbs Height: ___ft ___in

Has your child received vaccines? ❑ No ❑ Yes
if yes ❑ On regular schedule ❑ delayed schedule

Is your child exposed to secondhand smoke?
❑ Never ❑ In the Past ❑ Occasionally ❑ Daily

Indicate if your child has experienced the following:
❑ N/A ❑ Been unconscious due to illness or injury
❑ Serious illnesses, operation, or health emergency
❑ Motor vehicle accident ❑ Fractured a bone
Explain (include year(s)): _____

List over-the-counter/prescription drugs that your child is currently taking: ❑ N/A _____

Does your child have any genetic disorders or disabilities? ❑ No ❑ Yes (*If yes, explain*): _____

_____

Has your child's symptom/pain/reason for seeking chiropractic care happened BEFORE? ❑ No ❑ Yes

What treatment did you seek? ❑ N/A _____ How were your results? ❑ Good ❑ Poor

Help us identify past conditions or procedures that could be ***related to your child's main issue***:

❑ N/A ❑ Past surgeries ❑ Childhood diseases ❑ Past injuries *Explain:* _____

CHIEF COMPLAINT / HISTORY OF PRESENTING ILLNESS

Name: _____ Date: _____

What is the MAIN symptom/pain/reason you are seeking chiropractic care for your child?

PROBLEM/CONCERN #1: _____

- Rate your child's CURRENT pain/discomfort: ☐ /10 WHEN did the problem begin? _____
- Did your child do something/did something happen that caused/aggravated the problem?
  ❑ No ❑ Yes *If yes, explain:* _____
- Does the problem RADIATE outward? ❑ No ❑ Yes *If yes, where?* _____
- HOW OFTEN does your child experience the problem?
  ❑ always ❑ often ❑ occasionally ❑ rarely ❑ monthly ❑ weekly ❑ daily (❑ AM / ❑ PM)
- WHEN is the problem at its worst? ❑ Morning ❑ Mid-day ❑ Evening ❑ Other _____
- What RELIEVES the problem? _____ What makes the problem WORSE? _____

Are there any SECONDARY health concerns you wish to bring to our attention?

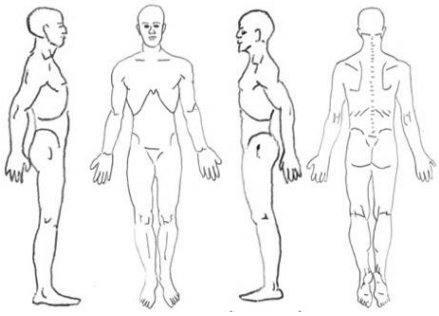
PROBLEM/CONCERN #2: ❑ N/A _____

- Rate your child's CURRENT pain/discomfort: ☐ /10 WHEN did the problem begin? _____
- Did your child do something/did something happen that caused/aggravated the problem?
  ❑ No ❑ Yes *If yes, explain:* _____
- Does the problem RADIATE outward? ❑ No ❑ Yes *If yes, where?* _____
- HOW OFTEN does your child experience the problem?
  ❑ Always ❑ Often ❑ Occasionally ❑ Rarely ❑ Monthly ❑ Weekly ❑ Daily (❑ AM / ❑ PM)
- WHEN is the problem at its worst? ❑ Morning ❑ Mid-day ❑ Evening ❑ Other _____
- What RELIEVES the problem? _____ What makes the problem WORSE? _____

Directions: On the diagrams to the RIGHT, CIRCLE the area(s) that to your child's pain/symptom(s):

How would you describe the problem(s)?

❑ Dull ache ❑ Deep/boring ❑ Numb
❑ Pounding ❑ Stiff/tight ❑ Sharp/stabbing
❑ Radiating ❑ Tingling ❑ Burning
❑ Other: _____



CHIROPRACTIC & HEALTH LIFESTYLE GOALS

What are the health and lifestyle goals you hope your child achieves while under chiropractic care?
PLEASE CHECK ALL THAT APPLY:

❑ Decrease the *severity* & *intensity* of my child's pain/problem(s)
❑ Decrease the *frequency* of my child's pain/problem(s) (how often my child experiences the pain/problem(s))
❑ With my child's chiropractic care, I hope they are able to… _____

ACTIVITIES OF DAILY LIVING

DIRECTIONS: Assess your child's ability / lack of ability to complete the following activities.

Activity	CAN COMPLETE *Without* Pain or Difficulty	CAN COMPLETE *With Minimal* Pain or Difficulty	CAN COMPLETE *With Significant* Pain or Difficulty	CANNOT COMPLETE Due to Pain	N/A
Bathe/Shower	❑	❑	❑	❑	❑
Groom Hair	❑	❑	❑	❑	❑
Brush Teeth	❑	❑	❑	❑	❑
Use Toilet	❑	❑	❑	❑	❑
Get Dressed	❑	❑	❑	❑	❑
Stand	❑	❑	❑	❑	❑
Walk	❑	❑	❑	❑	❑
Sit	❑	❑	❑	❑	❑
Squat	❑	❑	❑	❑	❑
Kneel	❑	❑	❑	❑	❑
Reach Overhead	❑	❑	❑	❑	❑
Bend Forward	❑	❑	❑	❑	❑
Turn Left	❑	❑	❑	❑	❑
Turn Right	❑	❑	❑	❑	❑
Move from Seated to Standing	❑	❑	❑	❑	❑
Sleep	❑	❑	❑	❑	❑
Eat	❑	❑	❑	❑	❑
Go Up/Down Stairs	❑	❑	❑	❑	❑
Get In/Out of Car	❑	❑	❑	❑	❑
Drive	❑	❑	❑	❑	❑
Use Computer	❑	❑	❑	❑	❑
Focus/Concentrate	❑	❑	❑	❑	❑
Prepare Food	❑	❑	❑	❑	❑
Household Chores	❑	❑	❑	❑	❑
Carry Bag/Purse	❑	❑	❑	❑	❑
Run/Hike	❑	❑	❑	❑	❑
Other: _____	❑	❑	❑	❑	❑

List Prescription & Non-Prescription drugs you take: _____

REVIEW OF SYSTEMS & ORGAN DYSFUNCTION

DIRECTIONS: Check the box(es) that apply to conditions that your child/your child's family members currently suffer from/have suffered from in the past. (Was your child Adopted? ❑ No ❑ Yes)

CONDITION	CURRENT	PAST	NEVER	
Acid Reflux/Heartburn/GERD	❑	❑	❑	
ADHD/ADD	❑	❑	❑	
Allergies	❑	❑	❑	
Anxiety	❑	❑	❑	
Arthritis/Joint Pain	❑	❑	❑	
Asthma/Difficulty Breathing	❑	❑	❑	
Autism Spectrum	❑	❑	❑	
Cancer	❑	❑	❑	
Carpal Tunnel Syndrome	❑	❑	❑	
Chest Pain	❑	❑	❑	
Depression	❑	❑	❑	
Diabetes	❑	❑	❑	
Difficulty Sleeping	❑	❑	❑	
Disc Problems	❑	❑	❑	
Dizziness/Vertigo	❑	❑	❑	
Ear Problems	❑	❑	❑	
Epilepsy	❑	❑	❑	
Fibromyalgia	❑	❑	❑	
Headaches/Migraines	❑	❑	❑	
Hemorrhoids	❑	❑	❑	
High/Low Blood Pressure	❑	❑	❑	
Infertility	❑	❑	❑	
Irritable Bowel Syndrome	❑	❑	❑	
Menstrual Dysfunction	❑	❑	❑	
Mood Changes/Irritability	❑	❑	❑	
Numbness/Tingling	❑	❑	❑	
Scoliosis	❑	❑	❑	
Sinus Problems	❑	❑	❑	
Swelling of Legs/Feet	❑	❑	❑	
TMJ/Jaw Pain	❑	❑	❑	
Tremors	❑	❑	❑	
* Organic / System Problems	❑	❑	❑	

* Select ALL that apply: ❑ Digestive ❑ Gallbladder ❑ Heart ❑ Liver ❑ Stomach ❑ Pancreas ❑ Reproductive ❑ Lung/Respiratory ❑ Urinary ❑ Kidney ❑ Prostate ❑ Vision ❑ Thyroid ❑ Skin ❑ Sexual ❑ Other(s) _____ *Explain*: _____

Child's Name: _____ Date: _____

TERMS OF ACCEPTANCE

Please read the below and if you have any questions, feel free to ask one of our staff members.

ARISE FAMILY CHIROPRACTIC NOTICE OF PRIVACY PRACTICE

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your **P**ersonal **H**ealth **I**nformation. In addition we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or as dictated by our office policy, we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. Once you have read this notice, please sign and return with the rest of your paperwork. Should you want to keep a copy of this form for your records, you may ask our front desk receptionist to create a copy.

PERMITTED DISCLOSURES:

1. Treatment purposes - discussion with other health care providers involved in your care.
2. Inadvertent disclosures - open treating area means open discussion. If you need to speak privately to the doctor, please let our staff know so we can place you in a private consultation room.
3. For payment purposes - to obtain payment from your insurance company or any other collateral source.
4. For workers compensation purposes - to process a claim or aid in investigation.
5. Emergency - in the event of a medical emergency, we may notify a family member.
6. For Public health and safety - in order to prevent or lessen a serious or eminent threat to the health or safety of a person or general public.
7. To Government agencies or Law enforcement - to identify or locate a suspect, fugitive, material witness or missing person.
8. For military, national security, prisoner and government benefits purposes.
9. Deceased persons - discussion with coroners and medical examiners in the event of a patient's death.
10. Telephone calls or emails and appointment reminders - we may call your home and leave messages regarding a missed appointment or apprize you of changes in practice hours or upcoming events.
11. Change of ownership - in the event this practice is sold, the new owners would have access to your PHI.

YOUR RIGHTS:

1. To receive an accounting of disclosures.
2. To receive a paper copy of the comprehensive "Detail" Privacy Notice.
3. To request mailings to an address different than residence.
4. To request Restrictions on certain uses and disclosures and with whom we release information to, although we are not required to comply. If, however, we agree, the restriction will be in place until written notice of your intent to remove the restriction.
5. To inspect your records and receive one copy of your records at no charge, with notice in advance (72 hours).
6. To request amendments to information. However, like restrictions, we are not required to agree to them.
7. To obtain one copy of your records at no charge, when timely notice is provided (72 hours). X-rays are original records and you are therefore not entitled to them. If you would like us to outsource them to an imaging center, to have copies made, we will be happy to accommodate you. However, you will be responsible for this cost.

COMPLAINTS: If you wish to make a formal complaint about how we handle your health information, please call Dr. Caitlyn Cortner at (770)406-8208 If she is unavailable, you may make an appointment with our receptionist to see her within 72 hours or 3 working days. If you are still not satisfied with the manner in which this office handles your complaint, you can submit a formal complaint to DHHS, Office of Civil Rights, 200 Independence Ave. SW, Room 509F HHH Building, Washington DC 20201.

Guardian Name (Printed): _____

Guardian Signature: _____ Date: _____

ARISE FAMILY CHIROPRACTIC NOTICE OF PRIVACY PRACTICE (CONTINUED)

I have received a copy of Arise Family Chiropractic Patient Privacy Notice. I understand my rights as well as the practice's duty to protect my health information, and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this "Notice of Privacy Practice" at a time in the future and will make the new provisions effective for all information that it maintains past and present. I am aware that a more comprehensive version of this "Notice" is available to me by the front desk receptionist at my request. At this time, I do not have any questions regarding my rights or any of the information I have received.

Guardian Name (Printed): _____ Date: _____

Guardian Signature: _____ Guardian DOB: _____

INFORMED CONSENT

A patient, in coming to the chiropractic doctor, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis. 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 he/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 what he/she is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the chiropractic physician. The chiropractic doctor provides a specialized, non-duplicating health care service. Your child's doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regimen. I understand that if my child is accepted as a patient by a physician at Arise Family Chiropractic, I am authorizing them to proceed with any treatment that they deem necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

Guardian Signature: _____ Date: _____

AUTHORIZATION FOR X-RAYS

X-rays are utilized in the office to help locate and analyze vertebral subluxations. These x-rays are not to be used to investigate for medical pathology. The doctors of Arise Family Chiropractic do not diagnose or treat medical conditions; however if any abnormalities are found, they will be brought to your attention so that you can seek proper medical advice. By my signature below I am acknowledging that the doctor and/or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

Guardian Signature: _____ Date: _____

(*Females Only*) Please check the box that applies to you - To the best of my knowledge:

- ❑ My child IS NOT pregnant at this time
- ❑ My child IS/I believe my child MAY BE pregnant, therefore I DO NOT authorize Arise Family Chiropractic to X-ray my child at this time.

Guardian Signature: _____ Date: _____

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I authorize Arise Family Chiropractic to release all necessary information concerning my health condition to my billing company, insurance company, attorney, and/or adjuster in order to process any claim for reimbursement of charges incurred by me. In addition, I authorize Arise Family Chiropractic to release any information regarding my health condition to other health care providers involved in my care. This assignment will remain in effect until revoked by me in writing. I agree that a photocopy of this form is to be considered as valid as the original. I confirm that all information I have provided is true and correct to the best of my knowledge. I confirm that I have read and fully understand this agreement and authorize Arise Family Chiropractic to proceed with chiropractic tests, diagnosis, analysis, and adjustments.

Guardian Signature: _____ Date: _____