104 W Redwood St Marshall, MN (507) 532-2655
732 Main St Wabasso, MN (507) 342-2000
366 E George St Ivanhoe, MN (507) 532-2655
info@fixenchiro.com

Electronic Health Records Child Intake Form

In compliance with requirements for the government CMS program

❒Male ❒Female **DOB**___/___/___ **Child's Social Security #** ___ ___ ___/___ ___/___ ___ ___ ___

Child's Last Name_____ **Child's First Name**_____

Address:_____
(City) (State) (Zip Code)

Home Phone: (____)____-_____ **Cell phone:** (____)____-_____

Parents Name: _____ **Medical Doctor name(s)**_____

Will an insurance company be <u>contributing</u> to your child's care? ❒No ❒ Yes
(If no, ask us about our great wellness plans)

Primary: _____ ***Secondary***: _____

Waiver: I authorize Fixen Chiropractic and the insurance company to process claims with my child's information. *(signature)*_____ *(date)* ___/___/___

Waiver: I authorize the insurance company to release data and to contribute to my child's care at Fixen Chiropractic. *(signature)*_____ *(date)* ___/___/___

Waiver: I have been offered a copy of Fixen Chiropractic's *HIPAA* and the following Person(s) have permission to any and all of my child's records (if applicable).

_____

*(signature)*_____ *(date)* ___/___/___

Waiver: I understand that there are minimal risks as stated in the *Informed Consent* and *Patient Consent*; I attest that I have been offered a copy of both forms.

*(signature)*_____*(date)* ___/___/___

Waiver: I, as a parent/legal guardian of _____ authorize appropriate chiropractic care.

_____*(date)*___/___/____
(Parent/Guardian Print Name) *(Parent/Guardian Signature)*

How was your child referred to Fixen Chiropractic? *(Check One)*

❒Patient _____ ❒Internet _____ ❒Location
❒Physician _____ ❒Radio ❒Other _____
❒Phone book _____ ❒Newspaper

Preferred Language: *(Fill in the Blank)* _____

Child's race is: *(Check One)*

❒American Indian/Alaska Native ❒Black ❒White
❒Asian ❒Pacific Islander ❒Other _____

Child's ethnicity is: *(Check One)*

❒ Hispanic or Latino ❒Not Hispanic or Latino

What is your child's major symptom/problem? _____

When did your child's symptoms begin? _____

Has your child had this problem before? ❒No ❒ Yes When? _____

Is your child's condition getting progressively worse? ❒No ❒ Yes

Pain scale: (*please circle*) *No pain* **1 2 3 4 5 6 7 8 9 10** *Severe pain*

When does your child feel your pain more? (*Check One*)

❒ Morning ❒ Afternoon ❒ Evening ❒ Night

How often does your child experience pain? (*Check One*)

❒None of the time ❒1-25% ❒26-50% ❒51-75% ❒76-99% ❒Constantly

Does it cause problems elsewhere? ❒No ❒ Yes Where? _____

What makes the condition better for your child? _____

What makes the condition worse for your child? _____

What does it interfere with? *(Check all that apply)*

❒Sleep ❒School ❒Routine ❒Recreation ❒Other_____

Has your child had any traumas? *(check all that apply)*

❒Falls ❒Concussions ❒Sport Injuries
❒Head injuries ❒Auto Accidents ❒Broken bones
❒ER visits ❒ Playground Injuries

❒Other *Please briefly describe:* _____

Has your child been seen by a chiropractor in the past? ❒No ❒ Yes
When? _____ Who? _____

Is your child currently taking medications, prescription drugs, and/or pain killers? ❒No ❒Yes
(Please include regularly used over the counter medications)

Prescription Name	Dosage	Frequency	What is it for?

Has your child had any surgeries/hospitalizations? ❒No ❒Yes *If yes, (fill in appropriate areas)*

Type of Surgery	Date	What was it for?	Any reaction?	
	___/___/____		❒Yes	❒No
	___/___/____		❒Yes	❒No

Conditions your child has or have had: *(Check all that apply)*

Migraines (G43) ❒/Headaches	❒	IBS(K58) ❒/Constipation	❒	ADD/ADHD (F90)	❒
Scoliosis (M41)	❒	Eating Disorder(s)_____	❒	Epilepsy (G40.9)	❒
Torticollis (M43.6)	❒	Colic (R10.83)	❒	Excessive Weight Loss/Gain	❒
Ear Ache/Ear Infections	❒	Frequent Choking	❒	Jaundice(P59.9<3 mo)	❒
Juvenile Rheumatoid Arthritis(M08.00)	❒	Asthma (J45)	❒	Type 1 Diabetes (E10.9)	❒
Psoriasis(L40.9)	❒	Eczema (L21.1)	❒	Hepatitis ❒ A(B15.9) ❒ B(B19.10) ❒ C(B19.20)	
Bladder Problems	❒	Sinus Infections	❒	Night Sweats	❒
Kidney Problems	❒	Frequent Colds/Flu/Illness/Fevers	❒	Night Terrors	❒
Bed Wetting	❒	Anxiety (F41.9)	❒	Cancer_____	❒
Acid Reflux (P78.83<3mo/K21.9>3mo)	❒	Depression (F41.8)	❒	Other_____	❒
Nausea/Vomiting	❒	Fatigue	❒		
Celiac Disease (K90.0)	❒	Austism (F84.0) ❒/Asperger's (F84.5)❒			

Summary of your child's family history. (*Please check type and list whom)*

Cancer

❒Thyroid(C73)_____ ❒Liver(C22.9)_____ ❒Ovarian(C56.9)_____ ❒Prostate(C61)_____
❒Colon(C18.9)_____ ❒Lung(C34.90)_____ ❒Brain(C71.9)_____ ❒Skin(C43.9)_____
❒Testicular(C62.90)_____ ❒Uterus(C55)_____ ❒Pancreatic(C25.9)_____ ❒Throat(C15.9)_____
❒Breast(F-C50.919/M-C50.929)_____ ❒Other_____

Diabetes

❒Type 1(E10.9)_____ ❒Type 2(E11.9)_____

Heart Attack/Disease(I25.2) ❒_____

Blood Pressure

❒High(I10)_____ ❒Low(I95.0)_____

Scoliosis(M41.9) ❒_____

Stenosis(M48.00) ❒_____

Disc Disorder

❒Thoracic/Lumbar(M51.9)_____ ❒Cervical(M50.90)_____

Is your child currently taking supplements or vitamins? ❒No ❒Yes
(Please include regularly used over the counter vitamins)

Supplement Name	Dosage	Frequency	What is it for?

Does your child have any allergies? ❒No ❒Yes *If yes, (fill in appropriate areas)*

Allergy Name	Reaction	Onset date	Additional comments
		___/___/____	
		___/___/____	

Has your child had any vaccinations and/or injections? ❒No ❒Yes *If yes, (fill in appropriate areas)*

Vaccination Name	Date	What was it for?	Any reaction?	
	___/___/____		❒Yes	❒No
	___/___/____		❒Yes	❒No

Do you want a receipt of a clinical summary after every visit *(These summaries are often blank as a result of the nature and frequency of chiropractic care.)*

❒ No, I **do not** want a summary receipt after every visit.
❒ Yes, I want a summary receipt even though it may be blank.

Parent/Guardian Signature: _____ Date ___/___/___

Office Use Only ***HT:*** ***WT:*** ***lbs*** ***BP:*** ***/*** ***O2:*** ***Pulse:***

□Verify info in CT □EHR Wizard □Alert □Doctor □Scan