CHILD AND ADOLESCENT NEW PATIENT INTAKE

Name:_____ Male ____ Female ____ Today'sDate:_____

Birth Date _____ Age _____ Height _____ Weight _____

Social Security # _____Female: Any possibility you are pregnant? NA ____ Yes ____ No ____

Parent's/Guardian Name _____Spouse's Name _____

Address:_____City_____State_____Zip_____

Cell Phone ( )_____Home ( )_____Work( )_____

Email Address: _____ Pediatrician's Name_____

Have you seen a Chiropractor before? Yes or No If yes, when? _____

Whom may we thank for referring you to our office? _____

Your Health Summary

Please ***Check*** *a*ll symptoms you have experienced in the last year, even if they do not seem related to your current problem

- ☐ Ear Infections
- ☐ Bed Wetting
- ☐ Recurrent Colds
- ☐ Recurrent Strep
- ☐ Recurrent Fevers
- ☐ Weakness/Fatigue
- ☐ ADHD/ADD
- ☐ Allergies
- ☐ Asthma/Wheezing
- ☐ Autistic Spectrum
- ☐ Sinus Trouble
- ☐ Bronchitis
- ☐ Stomach Aches
- ☐ Clumsiness
- ☐ Recurrent Thrush
- ☐ Nervousness
- ☐ Neurological Disorder
- ☐ Foot turned in or out
- ☐ Shoes wear out unevenly
- ☐ Colic
- ☐ Constipation/Diarrhea
- ☐ Chronic Cough
- ☐ Croup
- ☐ Cries a lot
- ☐ Eye/Hearing Problems
- ☐ Unusual Behavior
- ☐ Food Regurgitation
- ☐ Skin Disorder
- ☐ Irritability
- ☐ Weakness or Fatigue
- ☐ Learning Disorders
- ☐ Weak Immune System
- ☐ Scoliosis or Curvature
- ☐ Poor Sleeping
- ☐ Poor Concentration
- ☐ Trouble Walking/ Standing/Sitting
- ☐ Backaches
- ☐ Hip Leg or Foot Pain
- ☐ Knee Pain
- ☐ Painful Joints
- ☐ Arm or Hand Pain
- ☐ Headaches
- ☐ Neck Aches
- ☐ Poor Posture
- ☐ Shoulder Pain
- ☐ Pain Elbow/Wrist/Hand
- ☐ Pain Walking/ Standing/Sitting
- ☐ Sports Injuries

List chief complaints

1) _____2)_____3)_____

Are you currently under Dr's care for any other condition? Yes ☐or No ☐What?_____

List any current medications you are taking._____ What for?_____

Have you ever been hospitalized, had any surgeries, or broken any bones? Please list_____

Do you have any type of health insurance? Yes ☐or No ☐. If yes, which company_____

Do you have an HSA or HRA account? Yes ☐or No ☐

Patient's Signature (or guardian)_____Date_____

PERSONAL MEDICAL INFORMATION CONSENT FOR MESTDAGH CHIROPRACTIC CLINIC

The Health Insurance Portability Accountability Act of 1996 (HIPAA) requires that we receive your permission before we use the personal information in your medical records for any reason.
This consent form gives us permission to use your Protected Health Information (PHI) to carry out treatment, receive and/or as part of health care operations of our practice. HIPAA also requires us to have a written notice of our privacy policy describing how medical information about you may be used and disclosed. If you so desire, this written notice is available at the front desk for you to read. It is also posted in our waiting room for viewing.

You have the right to revoke, in writing, this consent form at any time, although any services performed prior to the revocation of this consent are covered by this consent.

*** Patient or Guardian's Signature: X_____Date: _____**

Restrictions:

Right to Revise Privacy Practices: As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our office's policies and practices may be required by changes in federal and state laws and regulations. Upon receipt, we will provide you with the most recent notice on an office visit. The revised policies and practices will be applied to all protected health information we maintain.

Doctor/StaffSignature:X_____Date:_____

INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE

I hereby request and consent to examination and to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays by Dr. Mestdagh and/or any other licensed Doctor of Chiropractic who now or in the future treats me while employed by, working or associated with or serving as back-up for Dr. Mestdagh. I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feel at the time, based on the facts then known, is in my best interest. I have read this consent and my signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment. I will also pose any questions or concern immediately to the Drs or staff.

*** Patient or Guardian's Signature: X_____Date: _____**

INSURANCE ASSIGNMENT OF BENEFITS - Read & Sign if you believe you have chiropractic insurance benefits.

I hereby instruct and direct my insurance company to pay by check made out and mailed directly to Mestdagh Chiropractic Clinic at 1550 N. Main Street, Unit A, Columbia, IL 62236. If my current policy prohibits direct payment to the doctor, then I hereby also direct you to make out the check to Mestdagh Chiropractic and mail it C/O Mestdagh Chiropractic Clinic at 1550 N. Main Street, Unit A, Columbia, IL 62236. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above mentioned assignee, and I have agree to pay, in a current manner, any balance of said professional service charges over and above this insurance payment. A photocopy of this assignment shall be considered as effective and valid as the original. I also authorize the release of any information pertinent to my case to any insurance company, adjuster or attorney involved with this case.

*** Patient or Guardian's Signature: X_____Date:_____**

FEMALE PATIENTS ONLY - Non-Pregnancy Verification for X-rays

Let it be known by all people by my signature that I am not pregnant. If it later becomes known that 1 was pregnant during this x-ray examination, that I do not hold Mestdagh Chiropractic Clinic and/or Laurie Mestdagh, DC liable.

Patient or Guardian's Signature:X_____Date:_____

CHILDREN & MINORS ONLY - Consent to Treat a Minor *(completed by parent or guardian)*

I hereby authorize the doctor and whomever he may designate as assistants to examine and administer chiropractic care as deemed necessary to my child.

Parent or Guardian's Signature:X_____Date:_____