Swickard Chiropractic Clinic of Shawnee, P.A.
17202 Midland Drive, Shawnee, KS 66217

Mark A. Swickard, DC
Bret Lickteig, DC

Pediatric Intake & History

PATIENT INFORMATION

Patient Name _____
Address _____
City _____
Sex □ Male □ Female Age ____ Birthdate _____
Doctor _____
I give you permission to send a brief case report to my child's doctor. □ Yes □ No Initial: _____
IN CASE OF EMERGENCY, CONTACT:
Name _____
Relationship _____
Contact Number _____

Mother's Name _____
Mother's Occupation _____
Mother's Phone _____
Mother's Email _____

Father's Name _____
Father's Occupation _____
Father's Phone _____
Father's Email _____
Who may we thank for referring you? _____
_____

HOW CAN WE HELP YOUR CHILD?

□ Wellness Checkup □ Other: _____ _____
If your child is already experiencing a symptom, please describe it: _____
_____
_____
_____
Has your child been treated on an emergency basis? □ Yes □ No
Please Describe: _____

PREGNANCY HISTORY

Did you experience any complication during your pregnancy? (Check all that apply)
□ Back/Other Pain □ Gestational Diabetes □ Pre/Eclampsia □ Strep B □ Nausea/Vomiting
□ Pre-Term □ Fatigue □ Swelling □ Other (please describe): _____
_____

BIRTH HISTORY

Type of birth (Check all that apply)
□ Hospital □ Birth Center □ Home □ Normal/Vaginal □ Breech □ Cesarean
□ Scheduled/Induced □ Epidural □ Problems during labor/delivery? (please describe): _____
_____
□ Antibiotics □ Congenital Anomalies □ Failure to Thrive □ Jaundice □ Meconium
□ Respiratory Distress □ Extended Hospitalization □ Other _____

GROWTH & DEVELOPMENT

Infant feeding: □ Breast □ Bottle □ Formula
Number of hours of sleep each night: _____ Quality of sleep: _____
At what age did the child:
Respond to sound: _____ Crawl: _____ Hold up head: _____
Stand: _____ Sit unsupported: _____ Walk unsupported : _____

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CHILDHOOD DISEASES, ILLNESSES & VACCINATIONS

Has your child had (check all that apply)?:

□ Chicken pox □ Measles □ Rubeola
□ Mumps □ Rubella □ Pertussis/Whooping Cough

Has your child ever suffered from (check all that apply)?:

□ Allergies	□ Broken Bones	□ Diabetes	□ Juvenile Rheumatoid Arthristis	□ Paralysis
□ Anemia	□ Chronic Ear Aches	□ Dizziness		□ Poor Appetite
□ Arm Problems	□ Colds/Flu	□ Fainting	□ Joint Problems	□ Ruptures/Hernias
□ Asthma	□ Colic	□ Headaches	□ Leg Problems	□ Sinus Trouble
□ Back Aches	□ Constipation/Diarrhea	□ Heart Trouble	□ Neck Problems	□ Tuberculosis
□ Bed Wetting	□ Convulsions/Seizures	□ Hyperactivity	□ Neuritis	□ Walking Problems
□ Behavioral Problems	□ Delayed Speech	□ Hypertension	□ Orthopedic Problems	

Have you vaccinated your child?

□ No □ Yes □ As scheduled □ Delayed schedule

ALLERGIES, MEDICATIONS, SURGERIES & FAMILY HISTORY

ALLERGIES (list) _____
_____
_____

MEDICATIONS (list) _____
_____
_____

SURGERIES (list) _____
_____
_____

FAMILY HISTORY (list) _____
_____
_____

SIBLINGS

How many children do you have? _____
Children's ages: _____
Children's health concerns: _____
_____

Number of pregnancies: _____
Are you currently pregnant? □ No □ Yes, I'm due: ____
Health concerns regarding this pregnancy? _____
_____

Authorization for Care of Minor

☐ **I hereby authorize this clinic and its doctor(s) to administer care as they so deem necessary to my son/daughter/ward.**

Signature: _____ Witnessed: _____ Date: _____

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Please start at the top of your body and work your way down, i.e. Headache, Neck Pain, etc.

Symptom 1 _____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity:
  5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? _____
  - Did the symptom begin suddenly or gradually? (circle one)
  - How did the symptom begin? _____
- What movements/activities make the symptom worse?
  - Please describe:_____
- What makes the symptom better?
  - Please describe:_____
- Describe the quality of the symptom (circle all that apply):
  - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging
    Other (please describe): _____
- Does the symptom radiate to another part of your body (circle one): yes no
  - If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? (circle one)
  - Morning Afternoon Evening Night Unaffected by time of day

Doctor's Notes:

Symptom 2 _____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity:
  5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? _____
  - Did the symptom begin suddenly or gradually? (circle one)
  - How did the symptom begin? _____
- What movements/activities make the symptom worse?
  - Please describe:_____
- What makes the symptom better?
  - Please describe:_____
- Describe the quality of the symptom (circle all that apply):
  - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging
    Other (please describe): _____
- Does the symptom radiate to another part of your body (circle one): yes no
  - If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? (circle one)
  - Morning Afternoon Evening Night Unaffected by time of day

Doctor's Notes:

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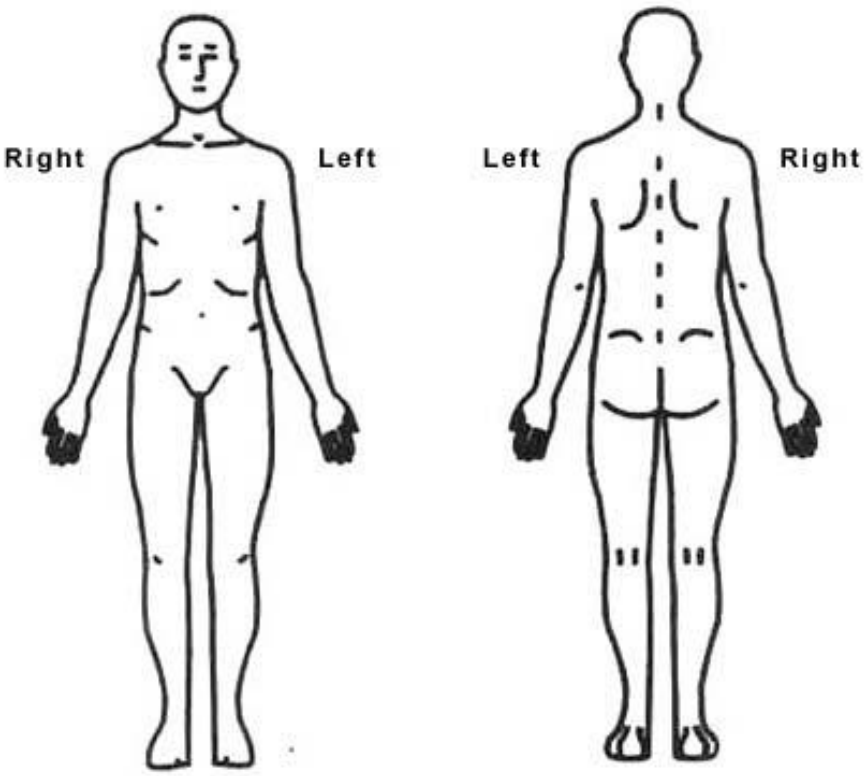
Please indicate sites of **pain** with an "X". (×××)
Does the **pain radiate (travel)**? If so, mark with an "arrow". (→→→)



Do you have headaches?

□ Yes □ No, skip to next page.

If yes, please answer the following:

a. **Mark where you get your headache(s) with an "X"**

b. **On a scale from 0-10, with 10 being the worst, indicate the intensity of your headache:** 1 2 3 4 5 6 7 8 9 10

c. **What describes your headaches?** (circle all that apply)
Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging, Other: _____

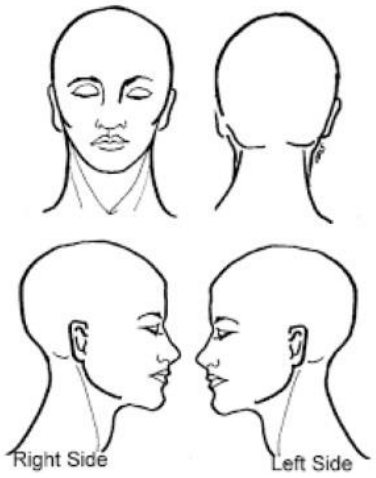
d. **How often do they occur?**
_____ X/week _____ X/month _____ Sporadic

e. **Are your headaches worse at certain times of the day or night?**
Morning Afternoon Evening Night Unaffected time of day

f. **When did your headaches begin?** _____

g. **What makes your headaches worse?** _____

h. **What makes your headaches better?** _____



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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 fund raising 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

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PRIMARY INSURANCE:

INSURANCE COMPANY:_____

INSURED'S NAME: _____RELATIONSHIP TO INSURED:_____

INSURED'S BIRTHDATE:_____ PHONE NUMBER:_____

ADDRESS:_____CITY:_____ STATE:_____ ZIP:_____

EMPLOYER NAME: _____

SECONDARY INSURANCE

INSURANCE COMPANY:_____

INSURED'S NAME: _____RELATIONSHIP TO INSURED:_____

INSURED'S BIRTHDATE:_____ PHONE NUMBER:_____

ADDRESS:_____CITY:_____ STATE:_____ ZIP:_____

EMPLOYER NAME: _____

RELEASE OF INFORMATION:

I _____ give permission to the staff at Swickard Chiropractic Clinic of Shawnee, P.A. to share any information related to my care, account and services to the following people:

NAME: (LAST, FIRST, MI): _____
RELATIONSHIP: _____
ADDRESS_____CITY:_____ STATE:_____ ZIP: _____
PHONE: _____

NAME: (LAST, FIRST, MI): _____
RELATIONSHIP: _____
ADDRESS_____CITY:_____ STATE:_____ ZIP: _____
PHONE: _____

NAME: (LAST, FIRST, MI): _____
RELATIONSHIP: _____
ADDRESS_____CITY:_____ STATE:_____ ZIP: _____
PHONE: _____

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of Chiropractic to provide me with chiropractic care, in accordance with this state's statutes. If my insurance will be billed, I authorize payment of medical benefits to Swickard Chiropractic Clinic of Shawnee, P.A. for services performed.

Patient or Guardian Signature _____ Date_____

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Pediatric Intake & History
Electronic Health Records Intake Form

This form complies with CMS EHR incentive program requirements

First Name: _____ Last Name: _____
Email address: _____@_____
Preferred method of communication for patient reminders (Circle one): Email / Phone / Mail
By providing my e-mail address, I understand that authorized personnel from Swickard Chiropractic may communicate with me regarding scheduling, treatment, receipts, statements, appointment reminders, health education, and promotional information. If you do not consent to e-mail communication, please initial here. _____

DOB: __/__/____ **Gender (Circle one):** Male / Female **Preferred Language: _____**

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked
Smoking Start Date (Optional): _____

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian)
Native Hawaiian or Pacific Islander / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications? *(Include regularly used over the counter medications)*

Medication	Dosage and Frequency (i.e. 5mg once a day, etc.)	Reason for Taking

Do you have any medication allergies?

Medication	Reaction	Onset Date	Additional Comments

☐ **I choose to decline receipt of my clinical summary after every visit** *(These summaries are often blank as a result of the nature and frequency of chiropractic care.)*

Patient Signature: _____ Date: _____

For office use only

Height: _____ Weight:_____ Blood Pressure:_____ /_____