Welcome To

New Practice Member Child Initial Interview

About the Child:

Last Name: ________________________ First: _____________________

Gender: Male Female Date of Birth: _______________________ Age: ___________________

About the Parent:

Name: _______________________ Birthdate:___________ Age:___________ Phone: _____________________

Mailing Address: _______________________________ City: _____________ State: _____ Zip: _____________

Email: _________________________________ Employer Name: _________________ Work Ph: ____________

Insurance Company: _________________ Insured's Name: _________________ Insured Birthdate:_________

Reason For This Visit:

Describe the reason for this visit): ____

____

Is the purpose of this visit related to: A Fall Sports Injury Auto Accident Other

Please Explain_____ ____

When did this condition begin: ____

Has the condition been: Staying the same Getting Worse Getting better

Have you seen other Doctors for this condition? ____

How would you describe the intensity/sensation? Sharp Dull Burning Numbness Other:___________________

Childs Health History:

Please circle all that apply or have applied to your child

Allergies	Asthma	ADHD	Bed Wetting	Breathing Problems
Colic	Constipation	Digestive Problems	Ear Problems	Frequent Cold
Headaches	Irritability	Sleeping Disorders	Tubes in Ears	Vision Problems

Other: ____

Is your child currently taking any medications? ____

Has your child ever been on antibiotics? ____

Pearson Chiropractic

Mother's Pregnancy and Labor:

During your pregnancy, did you use: Drugs Tobacco Medications Alcohol NA

Please Describe: ____

Describe your delivery: Please Explain:

Yes or No	Labor was chemically induced	________________________________
Yes or No	C-Section delivery	________________________________
Yes or No	Forceps or vacuum extraction	________________________________
Yes or No	Premature delivery	________________________________
Yes or No	Did you experience any illness when pregnant?	________________________________
Yes or No	Did you nurse the baby?	________________________________
Yes or No	Did the baby have colic?	________________________________
Yes or No	Did you choose to vaccinate your child?	________________________________

I CERTIFY THE INFORMATION ON THIS FORM IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

New Practice Member Name (please print):_________________________________ Date: ______/______/______

New Practice Member Signature: ____

Name and Signature of parent or legal guardian: ____________________________________ (If <18 years of age)

Notice of Privacy Policy

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment or practice operations will be made only after obtaining your consent.

- You may request restrictions on your disclosures.
- You may inspect and receive copies of your records within 30 days with a request
- You may request to view changes to your records
- In the future, we may contact you for appointment reminders, announcements and to inform you about our practice and its staff.

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up with multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician's certifications.

I have read and understand your Notice of Privacy Practices. A more complete description can be requested. I also understand that I can request, in writing, that you restrict how my personal information is used and or disclosed.

PATIENT NAME (PLEASE PRINT):____

Name and Signature of parent or legal guardian: ____________________________ (If <18 years of age)