



Pediatric Information Intake Form
(Ages 0-2)

Child's Personal Info:

Last Name: _____ First Name: _____ Middle Initial: _____
 DOB: _____ Gender: M / F
 Weight: _____ Height: _____ Name Suffix: Jr. / Sr.
 Preferred Language: Eng Span Student?: Yes No School: _____
 Street Address: _____
 City: _____ State: _____ Zip: _____

Parent's Personal Info:

Last Name: _____ First Name: _____ Middle Initial: _____
 DOB: _____ Gender: M / F
 Marital Status: M / S / W / D Employer: _____ Title: _____
 Address (Same as Child): _____
 City: _____ State: _____ Zip: _____
 Home Phone: _____ Work Phone: _____
 Parent's Cell: _____ Child's Cell: _____ Preferred Phone: Cell Home
 Email: _____ Reminder: Emails Texts Neither
 How did you hear about us? _____ (For text reminders) Verizon AT&T
 If referred by friend, can we send them a thank you? Yes No Other _____

Emergency Contact Info:

Contact Name: _____ Relationship to Patient: _____
 Phone: _____ Home Cell

Previous Chiropractic Care? Yes No Date of last Appt: _____

Why have you decided to have your child evaluated by a Chiropractor?

- My child is continuing ongoing care from another chiropractor.
- I would like my child's spine checked and understand the value.
- I have concerns about my child's health and am looking for answers.
- My child has a specific condition and I've learned that chiropractic may be able to help.
- I want to improve my child's immune function.

For Office Use Only: G CP MC Informed Consent

Pediatric History (0-2yrs)



Mankey Family
Chiropractic
Dr. Graham V. Mankey, D.C.
Dr. Allison Mankey, D.C.

Patient Name: _____

Date: _____

Reason(s) for your child's visit: _____

No Complaint/Wellness Care

History of Main Complaint (if Applicable):

Date symptom(s) began: _____ Is it: Constant Intermittent Activity-related
 What caused this condition/pain? _____ Is it getting: Better Worse Same
 What aggravates this condition/pain? _____ Rating: (best) 0 1 2 3 4 5 6 7 8 9 10 (Worst)
 What lessens this condition/pain? _____ % of Day: 0% 25% 50% 75% 100%
 Other Doctors seen for this condition: _____ Frequency? Daily Weekly Monthly
 Any home remedies? _____ Duration? Secs Mins Hours Days
 Is this condition worse during: Morning Afternoon Night Interfere with: Play Sleep Routine
 Any diagnostic tests performed? X-ray MRI CT Imaging Location: _____

Prenatal Profile: Adopted Prenatal history unknown Birth history unknown

Complications during pregnancy: No Yes (Brief description) _____
 Ultrasounds during pregnancy: No Yes How many & reason: _____
 Medications during pregnancy: No Yes List: _____
 Exposure to alcohol/cigarettes/2nd hand: No Yes
 Traumas/falls during pregnancy: No Yes List: _____

Birth History:

Place of birth: Home Hospital Center Use of: Midwife Doula None
 Duration of Pregnancy: _____ weeks Duration of Labor: _____ Hours Duration of birth: _____
 APGAR at birth: _____ /10 After 5 minutes _____ /10
 Any interventions? No Yes List: _____
 Medications delivered at birth? No Yes List: _____
 Was Delivery Abnormal? No Yes List: _____
 Evidence of birth trauma? No Yes List: _____

Patient Health History: Please mark any of the following that your child has now or has experienced:

- Reflux Frequent Colds/Croup Delay of milestones Bed wetting
- Digestive Issues Recurrent Fevers Abnormal crawling/gait Sleep Problems/Night Terrors
- Colic Ear Infections Tip toe walking Behavioral Issues
- Trouble Latching Rashes/Eczema Tremors/Shaking Frequent crying spells
- Torticollis/Head Tilt Plagiocephaly Seizures Weight challenges

Please list any health conditions not mentioned: _____

Current Health Lifestyle & Past History:

Food Source? (check all that apply) Breastfed Formula Cow's milk Solid Foods
 Around any smokers? Yes No How often? _____
 Any accidents/traumas? Yes No List: _____
 Any previous fractures? Yes No List: _____
 Any major illnesses? Yes No List: _____
 Any previous surgeries? Yes No List & Date: _____
 Any previous hospitalizations? Yes No List: _____
 Any medications given? Yes No List: _____
 Any allergies? Yes No List: _____

Informed Consent:

The doctor will use a very gentle and light force with her/his hands or with a mechanical device to manipulate the area treated. Your child may feel or hear a "click" or "pop," and may feel movement. Your chiropractor will recommend treatment she/he determines is most appropriate for your child's condition and wellbeing. Chiropractic care for your child is very safe and effective in facilitating proper development and function of their nervous system.

Authorization for care of a minor:

I hereby certify that the statements and answers given on this form are accurate to the best of knowledge and understand it is my responsibility to inform this office of any changes in my health. I authorize the doctor of Mankey Family Chiropractic to provide care to my child.

Parent Signature _____ Date _____

Informed Consent for Chiropractic Treatment of your Pain

The nature of chiropractic treatment: The doctor will use her/his hands or a mechanical device to manipulate the area treated. You may feel or hear a “click” or “pop,” and you may feel movement. Chiropractic treatment also includes activity advice, exercise, hot or cold packs, or electric stimulation. Your chiropractor will recommend treatment she/he determines is most appropriate for your condition.

Possible risks: Chiropractic treatment for pain is safe and the majority of patients experience decreased pain and improved mobility. Approximately 30% of patients experience slight increased pain in the treated area, possibly due to minor strain of muscle, tendon, or ligament. When this occurs within the first few days of treatment, the increased pain is brief and returns to baseline or improves over the next few days. Increased pain may also occur with exercise, heat, cold, and electrical stimulation. Possible skin irritation or burns may occur with thermal or electrical therapy.

Serious bodily harm is extremely rare and not an inherent risk of chiropractic treatment. Many variables can adversely affect one’s health, including previous injury, medications, osteoporosis, cancer and other illness or disease or condition. When these conditions are present, chiropractic treatment may be associated with serious adverse events, such as fracture, dislocation, or aggravation of previous injury to ligaments, intervertebral discs, nerves, or spinal cord. Symptoms of stroke or cerebrovascular injury alert patients to seek medical and/or chiropractic care. Your chiropractor is aware of this association and when appropriate may assess for symptoms and signs of stroke. *Please inform your chiropractor of all medications you are taking, including blood thinners, any surgeries you have had, and any other medical condition you have, including osteoporosis, heart disease, cancer, stroke, fracture, or previous severe injury.*

Other options for the treatment of pain include: *do nothing – live with it, over-the-counter medications, physical therapy, medical care, injections, or surgery.* There are hundreds of other treatments for pain. Most treatments that have potential benefit also have potential risk. You are encouraged to ask questions regarding possible risks of chiropractic treatment, and may use the space below for this purpose.

My signature below confirms that I have read the paragraphs above and that I understand what my chiropractor has told me about possible risks of chiropractic treatment and that I have had the opportunity to ask questions and have my questions answered. Also, I have fully disclosed to my chiropractor my medical history regarding the above specified complicating factors and all other conditions that have caused me pain in the past.

Patient Name

Signature

Date

Witness Name

Signature

Date



Mankey Family

Chiropractic

Dr. Graham V. Mankey, D.C.
Dr. Allison Mankey, D.C.

FINANCIAL POLICY

Payment is expected at the time of service. We accept cash, check, or charge (Visa or Master Card). Our Cash Price is discounted and is to be paid at time of service. The discount is forfeited if services are not paid in full at time of service. If we have to send a bill, the charge will reflect our usual (non-discounted) fees. We encourage you to take advantage of time of service discount.

There will be an additional \$25 fee for checks submitted with insufficient funds.

Balances over 60 days will incur an interest charge of 1.5% per month and after 90 days, an additional \$5.00 rebilling fee per statement will be charged

MISSED/CANCELED APPOINTMENTS:

We ask for a 24-hour notice for appointment cancellations. There will be a cancellation fee for each no show and appointment cancellation with less than 24 hours notice.

We have the right to charge you for your missed appointment if notice is less than 24 hours. We understand that sometimes last minute cancellations are unavoidable. Individual circumstances may be discussed with the office manager and/or the doctor.

INSURANCE:

Most insurance policies do cover chiropractic services, but the amount they pay varies from one policy to another, some pay 100% and some pay only a small amount.

Your insurance policy is a contract between you, your employer, and the insurance company. We are NOT a party to that contract. Our financial relationship is with you, not your insurance company.

IT IS IMPORTANT THAT YOU UNDERSTAND YOUR HEALTH OR ACCIDENT INSURANCE.

As a courtesy to our patients, we can check your insurance benefits for you. Verification of benefits or eligibility is not a guarantee of payment. Payment can only be made after the claim has been received and reviewed in regards to eligibility, benefits, medical necessity, and other limitations and/or exclusions. Your insurance is an agreement between you and your insurance company and you are responsible to know and understand your insurance benefits.

As a courtesy to our patients, our office will complete any necessary forms to help you collect from your insurance company. Patients will pay the amount up front and we will give you a completed form to submit to your insurance company. You should receive the credited amount however if the insurance company pays any amount directly to our office we will credit it back to your account. If there is an overpayment, it will be refunded to you. However, **you must clearly understand and agree that for all services rendered to you in our office, you are charged directly and you are personally responsible.**

I HAVE READ AND UNDERSTAND MY RESPONSIBILITY CONCERNING THE PAYMENT OF SERVICES.

SIGNATURE: _____ **Date:** _____



Health Insurance Portability and Accountability Act Form (HIPAA)

Consent for Purposes of Treatment, Payment & Healthcare Operations

In this document, “I” and “my” refer to the patient, and “Chiropractor” refers to Dr. Mankey or Mankey Family Chiropractic.

I consent to the use or disclosure of my protected health information by the Chiropractor for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my healthcare bills or to conduct health care operations of the Chiropractor. I understand that analysis, diagnosis or treatment of me by the Chiropractor may be conditioned upon my consent as evidenced by my signature below.

I understand that I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. The Chiropractor is not required to agree to the restrictions that I may request. However, if the Chiropractor agrees to a restriction that I request, the restriction is binding on the Chiropractor.

I have the right to revoke this consent, in writing, at any time, except that the Chiropractor has taken action in reliance on this Consent.

My “protected health information” means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. The protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I have a right to review the Notice of Privacy Practices prior to signing this document. This page is a modified version of our Notice of Privacy Practices. A full copy can be obtained upon request. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the Chiropractor.

The Chiropractor reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office of the Chiropractor and requesting a revised copy be sent in the mail, email, or asking for one at the time of my next appointment.

Patient Signature: _____ **Date:** _____