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

Pediatric Information Intake Form

(Ages 3-17)

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 (3-17yrs)

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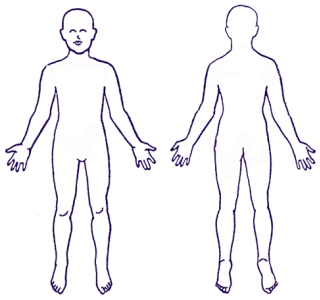
Patient Name:_____ Date:_____

Reason(s) for your child's visit: _____ ☐ No Complaint/Wellness Care

History of Main Complaint (if Applicable):

Date symptom(s) began: _____
What caused this condition/pain? _____
Is the condition/pain: ☐ Constant ☐ Intermittent ☐ Activity-related
Is the condition/pain getting: ☐ Better ☐ Worse ☐ Same
Any shooting/radiating pain? Y / N Where?_____
Any numbness? Y / N Where?_____
Rate the intensity: (Best) 0 1 2 3 4 5 6 7 8 9 10 (Worst)
Percentage of day that it's present: ☐ 0% ☐ 25% ☐ 50% ☐ 75% ☐ 100%
How often does it occur? ☐ Daily ☐ Weekly ☐ Monthly
How long does it last? ☐ Secs ☐ Mins ☐ Hours ☐ Days
What aggravates the condition/pain? _____
What lessens the condition/pain? _____
When is the condition the worst? ☐ Morning ☐ Afternoon ☐ Night
Does it interfere with: ☐ School ☐ Sleep ☐ Routine
Other Doctors seen for this condition: _____
Any home remedies? _____
Any diagnostic tests performed? ☐ X-ray ☐ MRI ☐ CT
Imaging location: _____



Using the symbols below, mark on the pictures where you feel pain or discomfort

Numbness	= = =
Dull Ache	OOO
Burning	XXX
Sharp/Stabbing	/ / /
Pins, Needles	+ + +
Other _____	^ ^ ^

Please mark any of the following that your child has currently or has experienced: ❒ NONE OF THE BELOW APPLY

❒ Headaches
❒ Migraines
❒ Asthma
❒ Respiratory tract infections
❒ Sinus Problems
❒ Ear Infections
❒ Frequent Colds/Croup
❒ Recurrent Fevers
❒ Frequent Illnesses
❒ Scoliosis
❒ Red/swollen/painful joints
❒ Eczema/Rashes
❒ Food Sensitivities
❒ Digestive Problems
❒ Constipation
❒ Frequent Diarrhea
❒ Frequent UTIs
❒ Growing pains
❒ Weight challenges
❒ Chest Pains
❒ Loss of Taste or Smell
❒ Pain waking you up at night
❒ Concussions
❒ Dizziness
❒ Double Vision
❒ Difficulty Speaking
❒ Difficulty Swallowing
❒ Nausea
❒ Nystagmus
❒ Numbness
❒ Fainting
❒ Loss of Consciousness
❒ Loss of Memory
❒ Heart Conditions
❒ Bed wetting
❒ Sleep Problems
❒ Night Terrors
❒ Tip toe walking
❒ Seizures
❒ Tremors/Shaking
❒ ADD/ADHD
❒ Autism
❒ Behavioral Issues

Current Health Lifestyle & Past History:

Does your child drink water? ☐ Yes ☐ No How much & how often?_____
Eat 7-14 servings of fruits & veggies/day? ☐ Yes ☐ No
Exercise regularly? ☐ Yes ☐ No Type?_____
Time spent on screens? ☐ Yes ☐ No How long?_____
Physical or Mental stress? ☐ Yes ☐ No Explain?_____
Sleeping posture? ☐ Side ☐ Stomach ☐ Back ☐ All of the above
Any accidents/trauma? ☐ Yes ☐ No List:_____
Any hobbies/sports injuries? ☐ 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? ☐ Yes ☐ No List:_____
Any allergies? ☐ Yes ☐ No List:_____
Family History of: ❒ Arthritis ❒ Heart/Blood Disease ❒ Cancer ❒ Diabetes ❒ Other ❒ Unknown

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**

FINANCIAL POLICY

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Chiropractic
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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:** _____

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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:** _____