Apex Chiropractic and Wellness Intake Form

120 Unionville Indian Trail Road C-102, Indian Trail, NC 28079
(704) 821-5000
apexchiropracticnc@gmail.com

PATIENT INFORMATION

Patient Name _____
Address _____
City _____ State _____ Zip Code _____
Sex M ☐ F ☐ Age _____ Birthday _____

Height _____ Weight _____
How did you hear about us? _____
Mother's Name _____
Mother's Occupation _____
Mother's Phone _____

IN CASE OF EMERGENCY, CONTACT

Name _____
Relationship _____
Contact Number _____

Father's Name _____
Father's Occupation _____
Father's Phone _____

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 the mother experience any complications during her 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? _____
_____

☐ Antibiotics ☐ Congenital Anomalies ☐ Failure to Thrive ☐ Jaundice ☐ Meconium
☐ Respiratory Distress ☐ Extended Hospitalization ☐ Other _____

GROWTH AND 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 head up: _____

Stand: _____ Sit unsupported: _____ Walk Unsupported: _____

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	☐ Colds/Flu	☐Heart Trouble	☐ Paralysis
☐ Anemia	☐ Colic	☐Hyperactivity	☐ Poor Appetite
☐ Arm Problems	☐ Convulsions/Seizures	☐Hypertension	☐ Ruptures/Hernias
☐ Asthma	☐ Delayed Speech	☐Juvenile RA	☐ Sinus Trouble
☐ Back Aches	☐ Diabetes	☐Joint Problems	☐ Tuberculosis
☐ Bed Wetting	☐ Digestive Issues	☐Leg Problems	☐ Walking Problems
☐ Behavioral Problems	☐ Dizziness	☐Neck Problems	☐ Other _____
☐ Broken Bones	☐ Fainting	☐Neuritis	_____
☐ Chronic Ear Aches	☐ Headaches	☐Orthopedic Problems	

Have you vaccinated your child?

☐ Yes ☐ No ☐ As Scheduled ☐ Delayed Schedule

ALLERGIES, MEDICATIONS, SURGERIES & FAMILY HISTORY

ALLERGIES (list)

_____

_____

MEDICATIONS (list)

_____

_____

SURGERIES (list)

_____

_____

FAMILY HISTORY (list)

_____

_____

Authorization for Care of Minor

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

Signed: _____ Date: _____

Witnessed: _____ Date: _____

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HEALTH CARE AUTHORIZATION FORM

THE PATIENT IDENTIFIED BELOW AUTHORIZES APEX CHIROPRACTIC AND WELLNESS TO USE AND OR DISCLOSE PROTECTED HEALTH INFORMATION IN ACCORDANCE WITH THE FOLLOWING:

- Apex Chiropractic and Wellness may use your health information to provide or coordinate your medical treatment and services. We may also prove that information to other healthcare providers who may assist in your treatment.
- Apex Chiropractic and Wellness may use and disclose your health information so that the services you receive in this office may be billed and/or collected from you, an insurance company or a third party. We may need to share information with your insurer so as to receive proper reimbursement and/or obtain prior approval for treatment and services. We may also use and disclose health information to third parties that may be responsible for costs and expenses such as family members.

SPECIFIC AUTHORIZATIONS

- I give permission for Apex Chiropractic and Wellness to use my phone number or address to contact you to confirm upcoming appointments.
- I give permission to Apex Chiropractic and Wellness to use my address and/or phone number to contact you with birth cards, holiday related cards, sympathy cards, thank you cards, and information about health alternatives or other health related information.
- I give Apex Chiropractic and Wellness permission that any pictures that are sent to the office for non-medical purposes can be posted in the office. (Holiday cards, birth announcements)
- I give permission to Apex Chiropractic and Wellness to disclose health information to a family member or friend who assists in caregiving and/or accompanies a child to the office such as stepparent, nanny, grandparent, etc. *PLEASE NOTE ANY UNAUTHORIZED PERSONS.*
- Other uses and disclose of protected health information for any purpose other than those identified in this notice can be made with your written authorization or that of a legal guardian. At any time, you or your legal guardian may revoke the authorization in writing. We will no longer release information upon receipt of the notice but cannot take back disclosures already made with your permission.

By signing this form you are giving Apex Chiropractic and Wellness permission to use and disclose your protected health information in accordance with treatment, payment or healthcare operations.

Print Name of Patient: _____

Signature of Patient/Legal Guardian: _____ Date: _____

Please list on the following lines, persons that have your permission to have access to your health records.

1. _____ 2. _____