WHITE MOUNTAIN
Chiropractic & Rehabilitation

1102 Route 119 Rindge, NH 03461
Tel: 603.899.5153 Fax: 603.899.5173

5 Dark Lane New Ipswich, NH 03071
Tel: 603.878.5387 Fax: 603.899.5173

140 Edmond Ave Portsmouth, NH 03801
Tel: 603.422.9220 Fax: 603.899.5173

PEDIATRIC INTAKE FORM

PATIENT INFORMATION

Child'sFirst/LastName:_____

Preferred Name:_____ Today's Date:_____

Height: _____ Weight: _____Date of Birth: _____ Age: _____Sex: M F

Child'sPediatrician:_____

How did you hear about White Mountain Chiropractic and Rehabilitation?_____

PARENT/GUARDIAN INFORMATION

Name:_____Relationship to Child:_____

Address:_____City:_____State: _____Zip:____

Home Phone:_____Cell phone:_____Email: _____

CHILD'S PURPOSE OF CARE

What is/are the health conditions you are concerned with today (please answer on behalf of your child if they are unable to do so)? _____

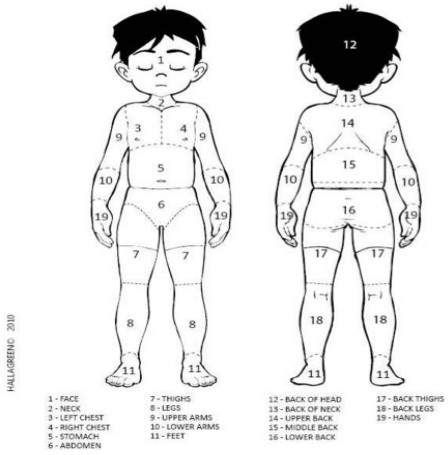
_____

When did this begin?_____Was there an accident or injury involved? Y N

Please circle below

Severity of complaint [0=none 10=worst]:

0 1 2 3 4 5 6 7 8 9 10



Is this condition: ___getting worse
___constant
___comes and goes

Is this condition interfering with: ___sleep
___daily routine
___meals

Have you had similar conditions in the past?: Y N
If so, when?:_____

Have you been treated by another provider (ex: MD, PT, Nutritionist) for this condition?: Y N

Results:_____

Have they ever been to a chiropractor before?: Y N If so, whom?: _____

GENERAL QUESTIONS/PRENATAL HISTORY

Any complications during pregnancy?: Y N Explain:_____

Medication taken during pregnancy:_____Cigarettes or alcohol during pregnancy: Y N

Birth intervention: Forceps Vacuum C-Section

Complications during delivery? Y N Explain:_____

How many times has your child been prescribed antibiotics?_____

Has your child received vaccinations? Y N Breast Fed: Y N How long?:_____

Food allergies or Intolerances? Y N List:_____

GENERAL HEALTH HISTORY

Any previous surgeries? Y N If so, please list with dates:_____

Current Medications:_____

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

___Headaches	___Postural Imbalances	___Growing Pains	___Scoliosis	___Tonsillitis
___Asthma	___Digestive Problems	___Ear Infections	___Sleep Problems	___Seizures
___Torticollis	___Bedwetting	___PDD/Autism	___ADD/ADHD	___Colic
___Frequent Fever	___Learning Difficulties	___Acid Reflux	___Hip Dysplasia	___Allergies
___Fractures	___Weakness	___Arm/Leg Problems	___Fainting	

How would your rate your child'd diet? ___Well Balanced ___Average ___High sugar/processed

Sleep Quality? ___Good ___Fair ___Poor

Does your child play sports? Y N Type:_____

Any other concerns you would like to discuss? _____

_____

_____ _____ _____

Patient Name Parent/Guardian Signature Date

Physician's Notes:

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INSURANCE AND TIME OF SERVICE PAYMENT

Our office is pleased to accept your insurance plan.The copay, deductible and any amount that is not paid by the insurance company are the patient's responsibility. The patient will be billed for any balance not paid by the insurance company within 90 days, unless other arrangements are made with White Mountain Chiropractic & Rehabilitation.

Services or therapies that may not be covered, specifically by **Medicare**, include but are not limited to:

New Patient Initial Exam/Re-exam
Physiotherapy (Heat, Cold, Electric Muscle Stimulation)
Therapy Extremity Chiropractic Adjustment
Rehabilitation Exercises
Soft Tissue
Taping

Estimated Time of Service cost for these **non-covered services/therapies may range from $5.00-$45.00**

TIME OF SERVICE (TOS) DISCOUNT

Whether your insurance covers chiropractic services or not, White Mountain Chiropractic & Rehabilitation offers a Time of Service (TOS) Discount to everyone. In order to qualify for this discounted payment option, all fees must be paid the same day the services are provided (at the discounted rate). If you would like to be reimbursed for the TOS amount by your insurance, it is your responsibility to submit the documentation.

ASSIGNMENT OF INSURANCE PROCEEDS

If you do have insurance, by agreeing to this assignment, we will direct your insurance company to make payments for your chiropractic, physiotherapy, physical rehabilitation or any other reimbursable treatment or evaluations you receive directly to White Mountain Chiropractic & Rehabilitation.

In exchange for services and supplies rendered, I do assign to White Mountain Chiropractic & Rehabilitation any insurance proceeds, including accident and health insurance, auto insurance benefits and bodily injury claim awards up to the amount of any unpaid balance on my account. In giving this assignment, I acknowledge that I am responsible for all charges to my account.

Patient Name _____ Patient Signature _____ Date _____

If Patient is a Minor,

Parent/Guardian Name _____ Relationship to Patient _____ Date _____

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INFORMED CONSENT FOR EXAMINATION, TREATMENT, & PRIVACY PRACTICES

I hereby request and consent to the performance of examination and treatment on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic Dr. Colby B. Lamson, Dr. Rachel L. Morgan and/or other licensed doctors of chiropractic who now or in the future work at White Mountain Chiropractic & Rehabilitation or any other office or clinic. Treatment includes chiropractic manipulation/adjustments and other chiropractic procedures, including various modes of physiotherapy, soft-tissue therapy, rehabilitative therapy and/or referral for diagnostic tests as necessary,

I have had an opportunity to discuss with the doctor of chiropractic named above and/or with other office personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

The Notice of Privacy Practices has been made available to me and I consent to the use or disclosure of my protected health information for the purpose of analyzing, diagnosing, or providing treatment to me, obtaining payment for my care or to conduct health care operations of this office. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information and my rights and duties of this office with respect to my protected health information

Patient Name	Patient Signature	Date

If Patient is a Minor,

Parent/Guardian Name	Relationship to Patient	Date