Guthrie Chiropractic
816.608.3691

Pediatric Chiropractic Intake Form

Patient Information

Child's Full Name: _____

Date of Birth: __ __/__ __/__ __ __ __

Age: _____

Gender: _____

Parent/Guardian Name(s): _____

Address: _____

City/State/ZIP: _____

Phone: _____ Text Reminders: Yes _____ No _____

Email: _____

Who may we thank for referring you to our office?: _____

Health History

Primary reason for today's visit: _____

When did this problem begin?: _____

Was there an injury or trauma associated?: ☐ Yes ☐ No If yes, please describe:

_____

Has your child received chiropractic care before?: ☐ Yes ☐ No If yes, when?:

_____

Has your child received other forms of care for this condition?: ☐ Yes ☐ No If yes, by whom (type of doctor)?: _____

Birth History

Birth Type: ☐ Vaginal ☐ C-section

Birth Place: ☐ Hospital ☐ Home ☐ Birthing Center

Complications during pregnancy, labor, or delivery?:_____

Duration of Labor/Active Labor: _____

Was the child premature?: ☐ Yes ☐ No If yes, how early,? _____

Birth weight: _____ lbs Birth length: _____ in

APGAR score (if known): _____

Was there any use of: ☐ Forceps ☐ Vacuum ☐ Induction ☐ Epidural ☐ Other: _____

Any difficulty nursing or latching?: ☐ Yes ☐ No If yes, describe: _____

Did the child have colic or reflux?: ☐ Yes ☐ No

Was the child tongue-tied or lip-tied?: ☐ Yes ☐ No

Chemical Stressors

Does your child take any medications or supplements?: ☐ Yes ☐ No List: _____

_____

Was your child formula-fed or breastfed?: ☐ Formula ☐ Breastfed ☐ Both

If formula-fed, what brand/type?: _____

Has your child received antibiotics?: ☐ Yes ☐ No How many times?: _____

Any hospitalizations or surgeries?: _____

Any known food sensitivities or allergies?: _____

Is there smoking exposure in the home?: ☐ Yes ☐ No

Traumatic Stressors

Any falls, bumps, or accidents since birth?: ☐ Yes ☐ No Describe:

_____

Any hospitalizations or surgeries?: ☐ Yes ☐ No If yes, describe:

_____

Any known head or neck injuries?: ☐ Yes ☐ No

Any use of baby jumpers, walkers, or exersaucers?: ☐ Yes ☐ No

Has your child been in a car seat for extended periods daily?: ☐ Yes ☐ No

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Miscellaneous

How many hours of sleep does your child get per night?: _____

Does your child participate in sports or physical activities?: ☐ Yes ☐ No Which ones?:

_____

Any behavioral, emotional, or learning concerns?:

_____

Any night terrors, sleepwalking or bed wetting? ☐ Yes ☐ No If yes, describe:

_____

Developmental Milestones

1–3 Months

☐ Supports head/upper body when on stomach ☐ Turns head side to side

☐ Follows faces or objects with eyes ☐ Responds to sounds

☐ Smiles responsively ☐ Moves arms and legs symmetrically

☐ Opens and shits hands ☐ Makes cooing sounds

4–7 Months

☐ Rolls front to back and back to front ☐ Reaches and grasps objects

☐ Brings hands or toys to mouth ☐ Sits/stands with or without support

☐ Laughs and babbles ☐ Transfers toys from one hand to another

8–12 Months

☐ Crawls or scoots ☐ Responds to name and simple instructions

☐ Pulls to stand ☐ Cruises along furniture

☐ Picks up small objects with thumb and finger ☐ Says simple words like 'mama' or 'dada'

☐ Holding spoon or book by themselves ☐ In and out of sitting position alone

☐ Walking independently or supported

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Family Health History

Please check if any of the following apply to your child's immediate family:

☐ Asthma/Allergies ☐ Heart Disease

☐ High Blood Pressure ☐ Scoliosis

☐ Diabetes ☐ Digestive Issues

☐ Migraines ☐ ADHD/ADD

☐ Other: _____

Other Relevant Information or Concerns

_____

_____

_____

_____

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1110 Branch St, Platte City MO 64079

Consent to Treat a Minor

Patient Information

Minor's Full Name: _____

Date of Birth: _____

Age: _____

Parent/Guardian Name: _____

Relationship to Minor: _____

Purpose of Care

This consent form authorizes Dr. Dylan Guthrie or Dr. Taylor to perform chiropractic examinations, adjustments, and related procedures deemed necessary to support the health and well-being of the above-named minor.

Description of Chiropractic Care

Chiropractic care may include spinal adjustments, physical therapy modalities, soft tissue techniques, exercises, and lifestyle recommendations. The purpose of chiropractic care is to reduce spinal subluxations, improve nervous system function, and support overall health.

While chiropractic care is considered safe and effective, no guarantee of specific results is made. Possible side effects are generally mild and temporary and may include soreness, stiffness, or slight discomfort.

Consent and Authorization

I, the undersigned parent or legal guardian of the above-named minor, hereby:

1. Authorize the doctors at Guthrie Chiropractic to administer chiropractic care and related procedures to my child as deemed appropriate.
2. Acknowledge that the nature and purpose of chiropractic procedures have been explained to me and that I may ask questions at any time.
3. Understand that I may withdraw this consent in writing at any time.

Acknowledgment and Signature

I have read and fully understand the above statements and consent to chiropractic treatment for my child.

Parent/Guardian Printed Name: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

HIPAA ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of Guthrie Chiropractic "Notice of Privacy Practices'. This notice describes how Guthrie Chiropractic may use and disclose my protected health information, certain restrictions on the use and disclosure of my health information, and rights I may have regarding my protected health information. By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. Your information will be disclosed to your insurance company and physician for billing purposes and to federal and state reporting agencies. You have the right to revoke tis content, in writing, except where we have already made disclosures in reliance on the content.

INFORMED CONSENT

I hereby authorize the doctor to examine and treat my conditions deemed appropriate through the use of chiropractic care, and I give authority for those procedures to be performed. I understand that chiropractic is no an exact science and that my care may involve judgments based upon facts and information known to the doctor. The doctor uses judgement to anticipate or explain risks and complications and an undesirable result does not indicate an error in judgment. No guarantee for results can be made or expected but rather I wish to rely on the doctor to choose and recommend a best course of treatment based upon facts known that is in my best interests. I further understand that there are certain degrees of risks associated with chiropractic health care and physical therapy, which includes rarely, but not limited to fractures, disc injuries, strokes, and strain/sprains and am therefore willing to accept and consent to the risk associated with the care that I am about to receive.

AUTHORIZATION

I give Guthrie Chiropractic the right to release any records, and pertinent material to any third party. I hereby instruct, direct, and authorize my insurance company to pay directly to Guthrie Chiropractic, for any professional services.

MY SIGNATURE IS AN ACKNOWLEGEMENT THAT I HAVE READ AND UNDERSTAND TE POLICIES ABOVE AND AGREE TO ABIDE BY THE SAME

CANCELLATION/ NO SHOW APPOINTMENT POLICY

We understand tat there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you or a visit, due to seemingly "full" appointment book.

IF YOU FAIL TO CANCEL OR RESCHEDULE YOUR APPOINTMENT WITHIN ONE HOUR OF YOUR SCHEDULED TIME, YOU WILL BE CHARGED A $25 FEE; THIS WILL NOT BE COVERED BY YOUR INSURANCE CARRIER.

PRINT NAME:_____

SIGNATURE: _____ DATE: _____