



104 W Redwood St Marshall, MN (507) 532-2655
 134 State Highway 68 Wabasso, MN (507) 342-2000
 2340 26th St. Slayton, MN (507) 836-8971
 202 E 1st St. Minneota, MN (507) 872-5200
info@fixenchiro.com

Electronic Health Records Child Intake Form

In compliance with requirements for the government CMS program

Male Female **DOB** ___/___/___ **Child's Social Security #** ___ ___ ___ / ___ ___ ___

Child's Last Name _____ **Child's First Name** _____

Address: _____
(City) (State) (Zip Code)

Home Phone: (____) ____ - ____ **Cell phone:** (____) ____ - ____

Parents Name: _____ **Medical Doctor name(s)** _____

Will an insurance company be contributing to your child's care? No Yes
(If no, ask us about our great wellness plans)

Primary: _____ **Secondary:** _____

Waiver: I authorize Fixen Chiropractic and the insurance company to process claims with my child's information. *(signature)* _____ *(date)* ___/___/___

Waiver: I authorize the insurance company to release data and to contribute to my child's care at Fixen Chiropractic. *(signature)* _____ *(date)* ___/___/___

Waiver: I have been offered a copy of Fixen Chiropractic's *HIPAA* and the following Person(s) have permission to any and all of my child's records (if applicable).

(signature) _____ *(date)* ___/___/___

Waiver: I understand that there are minimal risks as stated in the *Informed Consent* and *Patient Consent*; I attest that I have been offered a copy of both forms.
(signature) _____ *(date)* ___/___/___

Waiver: I, as a parent/legal guardian of _____ authorize appropriate chiropractic care.

(Parent/Guardian Print Name) (Parent/Guardian Signature) (date) ___/___/___

How was your child referred to Fixen Chiropractic? *(Check One)*

Patient _____ Internet _____ Location _____
 Physician _____ Radio _____ Other _____
 Phone book _____ Newspaper _____

Preferred Language: *(Fill in the Blank)* _____

Child's race is: *(Check One)*

American Indian/Alaska Native Black White
 Asian Pacific Islander Other _____

Child's ethnicity is: *(Check One)*

Hispanic or Latino Not Hispanic or Latino

What is your child's major symptom/problem? _____

When did your child's symptoms begin? _____

Has your child had this problem before? No Yes When? _____

Is your child's condition getting progressively worse? No Yes

Pain scale: (please circle) No pain 1 2 3 4 5 6 7 8 9 10 Severe pain

When does your child feel your pain more? (Check One)

Morning Afternoon Evening Night

How often does your child experience pain? (Check One)

None of the time 1-25% 26-50% 51-75% 76-99% Constantly

Does it cause problems elsewhere? No Yes Where? _____

What makes the condition better for your child? _____

What makes the condition worse for your child? _____

What does it interfere with? (Check all that apply)

Sleep School Routine Recreation Other _____

Has your child had any traumas? (check all that apply)

Falls Concussions Sport Injuries

Head injuries Auto Accidents Broken bones

ER visits Playground Injuries

Other Please briefly describe: _____

Has your child been seen by a chiropractor in the past? No Yes

When? _____ Who? _____

Is your child currently taking medications, prescription drugs, and/or pain killers? No Yes
 (Please include regularly used over the counter medications)

Prescription Name	Dosage	Frequency	What is it for?

Has your child had any surgeries/hospitalizations? No Yes If yes, (fill in appropriate areas)

Type of Surgery	Date	What was it for?	Any reaction?
	__/__/__		<input type="checkbox"/> Yes <input type="checkbox"/> No
	__/__/__		<input type="checkbox"/> Yes <input type="checkbox"/> No

Conditions your child has or have had: (Check all that apply)

Migraines (G43) <input type="checkbox"/> /Headaches <input type="checkbox"/>	IBS(K58) <input type="checkbox"/> /Constipation <input type="checkbox"/>	ADD/ADHD (F90) <input type="checkbox"/>
Scoliosis (M41) <input type="checkbox"/>	Eating Disorder(s) _____ <input type="checkbox"/>	Epilepsy (G40.9) <input type="checkbox"/>
Torticollis (M43.6) <input type="checkbox"/>	Colic (R10.83) <input type="checkbox"/>	Excessive Weight Loss/Gain <input type="checkbox"/>
Ear Ache/Ear Infections <input type="checkbox"/>	Frequent Choking <input type="checkbox"/>	Jaundice(P59.9<3 mo) <input type="checkbox"/>
Juvenile Rheumatoid Arthritis(M08.00) <input type="checkbox"/>	Asthma (J45) <input type="checkbox"/>	Type 1 Diabetes (E10.9) <input type="checkbox"/>
Psoriasis(L40.9) <input type="checkbox"/>	Eczema (L21.1) <input type="checkbox"/>	Hepatitis <input type="checkbox"/>
Bladder Problems <input type="checkbox"/>	Sinus Infections <input type="checkbox"/>	<input type="checkbox"/> A(B15.9) <input type="checkbox"/> B(B19.10) <input type="checkbox"/> C(B19.20)
Kidney Problems <input type="checkbox"/>	Frequent Colds/Flu/Illness/Fevers <input type="checkbox"/>	Night Sweats <input type="checkbox"/>
Bed Wetting <input type="checkbox"/>	Anxiety (F41.9) <input type="checkbox"/>	Night Terrors <input type="checkbox"/>
Acid Reflux (P78.83<3mo/K21.9>3mo) <input type="checkbox"/>	Depression (F41.8) <input type="checkbox"/>	Cancer _____ <input type="checkbox"/>
Nausea/Vomiting <input type="checkbox"/>	Fatigue <input type="checkbox"/>	Other _____ <input type="checkbox"/>

Summary of your child's family history. *(Please check type and list whom)***Cancer**

Thyroid(C73) _____ Liver(C22.9) _____ Ovarian(C56.9) _____ Prostate(C61) _____
 Colon(C18.9) _____ Lung(C34.90) _____ Brain(C71.9) _____ Skin(C43.9) _____
 Testicular(C62.90) _____ Uterus(C55) _____ Pancreatic(C25.9) _____ Throat(C15.9) _____
 Breast(F-C50.919/M-C50.929) _____ Other _____

Diabetes

Type 1(E10.9) _____ Type 2(E11.9) _____

Heart Attack/Disease(I25.2) _____

Blood Pressure

High(I10) _____ Low(I95.0) _____

Scoliosis(M41.9) _____

Stenosis(M48.00) _____

Disc Disorder

Thoracic/Lumbar(M51.9) _____ Cervical(M50.90) _____

Is your child currently taking supplements or vitamins? No Yes

(Please include regularly used over the counter vitamins)

Supplement Name	Dosage	Frequency	What is it for?

Does your child have any allergies? No Yes *If yes, (fill in appropriate areas)*

Allergy Name	Reaction	Onset date	Additional comments
		__/__/__	
		__/__/__	

Has your child had any vaccinations and/or injections? No Yes *If yes, (fill in appropriate areas)*

Vaccination Name	Date	What was it for?	Any reaction?
	__/__/__		<input type="checkbox"/> Yes <input type="checkbox"/> No
	__/__/__		<input type="checkbox"/> Yes <input type="checkbox"/> No

Do you want a receipt of a clinical summary after every visit *(These summaries are often blank as a result of the nature and frequency of chiropractic care.)*

No, I **do not** want a summary receipt after every visit.

Yes, I want a summary receipt even though it may be blank.

Parent/Guardian Signature: _____

Date / /

Office Use Only **HT:** **WT:** **lbs** **BP:** / **O2:** **Pulse:**

Verify info in CT EHR Wizard Alert Doctor Scan