Addasu Family Chiropractic | Dr. Kevin Powell
1585 Mallory Lane, Suite 208, Brentwood, TN 37027
P (615) 590-9618 |F (615) 5909619 |www.addasufamilychiro.com

PEDIATRIC INTAKE PAPERWORK

HELLO AND WELCOME TO ADDASU FAMILY CHIROPRACTIC!

Who may we thank for referring you / how did you hear about us? ____________________

Please fill out the following information and to the best of your ability.

PATIENT'S NAME: ____________________ HR#: ____________ DATE: ____________

PERSONAL INFORMATION

Child's Name: ____________________
Child's Preferred Name: ____________________
Pediatrician/ Family PCP: ____________________
Address: ____________________
Guardian #1: ____________________
Phone: (❏ Cell ❏ Home ❏ Work): ____________________
Guardian #2: ____________________
Phone: (❏ Cell ❏ Home ❏ Work): ____________________
Who is responsible for this child's finances?
❏ Guardian #1 ❏ Guardian #2 ❏ Both
Siblings (Name(s)/Age(s)): ____________________

Birthdate: _____-_____-_____ Age: _______ ❏ Male ❏ Female
Do you have insurance? ❏ Yes ❏ No
City/State: ____________________
City: ____________________ State: _____ Zip: ___________
Relationship to Child: ____________________
Email: ____________________
Relationship to Child: ____________________
Email: ____________________
What is the relationship between Guardians #1 and #2?
❏ Married ❏ Divorced ❏ Other: ____________________
Child's Hobbies: ____________________

PRENTAL, BIRTH, & INFANCY HISTORY

If your child is over 5, skip to PERSONAL HEALTH HISTORY

Birth: Height: __ in Weight: ___ lbs ___ oz
Name of ❏ Doctor/❏ Midwife: ____________________
At who many weeks of pregnancy was your child born? _______
Delivery method: ❏ Vaginal ❏ C-Section ❏ VBAC
List of any drugs/medication the mother was on during pregnancy: ❏ N/A ____________________
List of any complications, serious illness, or health emergency that the mother experienced during the birth or pregnancy: ❏ N/A
____

PERSONAL HEALTH HISTORY

Purpose of this visit: ❏ Wellness Check-up ❏ Injury or Accident ❏ Other
Please explain: ____________________
If your child is experiencing **pain/discomfort, please identify where and for how long:**
____
____
When did the problem first begin? Date: _____-_____-_____ ❏ Unknown ❏ Gradual ❏ Sudden
Has this problem occurred before? ❏ No ❏ Yes ***If yes***, when? ____________________
Any bowel or bladder problems since this problem began? ❏ No ❏ Yes ***If yes***, describe: ____________________
____
Have you seen any other doctors for this problem? ❏ No ❏ Yes **If yes**, whom? ____________________
How long ago? _____ Days _____ Weeks _____ Months _____ Years
What were the results of past treatment? ____________________
How is this problem NOW? ❏ Rapidly Improving ❏ Improving Slowly ❏ About the Same ❏ Gradually Worsening ❏ On and Off
Please list any medication(s) taken for this problem: ____________________
Has your child ever sustained an injury playing organized sports? ❏ No ❏ Yes **If yes,** please explain:
____
____
Has your child ever sustained an injury in an auto accident? ❏ No ❏ Yes **If yes,** please explain:
____
____
List Prescription & Non-Prescription drugs you take: ____________________
____

HAS YOUR CHILD EVERY SUFFERED FROM – *Check all that apply*

- ❑ Headaches
- ❑ Dizziness
- ❑ Fainting
- ❑ Seizures/Convulsions
- ❑ Heart Trouble
- ❑ Chronic Earaches
- ❑ Sinus Trouble
- ❑ Scoliosis
- ❑ Bed Wetting
- ❑ Fall in baby walker
- ❑ Fall off bicycle
- ❑ Fall from changing table
- ❑ Orthopedic Problems
- ❑ Neck Problems
- ❑ Arm Problems
- ❑ Leg Problems
- ❑ Joint Problems
- ❑ Backaches
- ❑ Poor Posture
- ❑ Anemia
- ❑ Colic
- ❑ Fall from bed or couch
- ❑ Fall from high chair
- ❑ Fall off monkey bars
- ❑ Digestive Disorders
- ❑ Poor Appetite
- ❑ Stomach Aches
- ❑ Reflux
- ❑ Constipation
- ❑ Diarrhea
- ❑ Hypertension
- ❑ Colds/Flu
- ❑ Broken Bones
- ❑ Fall from crib
- ❑ Fall off slide
- ❑ Fall off skateboard/skates
- ❑ Behavioral Problems
- ❑ ADD/ADHD
- ❑ Ruptures/Hernia
- ❑ Muscle Pain
- ❑ Growing Pains
- ❑ Asthma
- ❑ Walking Trouble
- ❑ Sleeping Problems
- ❑ Fall off swing
- ❑ Fall down stairs

❑ Allergies to ____

❑ Other: ____

CHIROPRACTIC & HEALTH LIFESTYLE GOALS

What are your health and lifestyle goals you hope to achieve while under chiropractic care?

PLEASE CHECK ALL THAT APPLY:

- ❑ Decrease the severity & intensity of my child's pain/problem(s)
- ❑ Decrease the frequency of my child's pain/problem(s) (how often the pain/problem(s))
- ❑ By the end of my child's corrective chiropractic care, I hope to be able to ________________________________

I hereby authorize payment to be made directly to Addasu Family Chiropractic, for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application, or copies thereof, for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to Addasu Family Chiropractic for any and all services I receive at this office.

____ ______ - ______ - ______

Patient or Authorized Person's Signature **Date Completed**

____ ______ - ______ - ______

Doctor's Signature **Date Form Reviewed**

ACTIVITIES OF DAILY LIVING

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

Activity	No Effect	Minimal Pain (can do)	Significant Pain (limited activity)	Unable to Perform	N/A
Bath/Shower	❑	❑	❑	❑	❑
Groom Hair	❑	❑	❑	❑	❑
Brush Teeth	❑	❑	❑	❑	❑
Use Toilet	❑	❑	❑	❑	❑
Dress Upper Body	❑	❑	❑	❑	❑
Dress Lower Body	❑	❑	❑	❑	❑
Daily Physical Activities	❑	❑	❑	❑	❑
Stand	❑	❑	❑	❑	❑
Walk	❑	❑	❑	❑	❑
Sit	❑	❑	❑	❑	❑
Squat	❑	❑	❑	❑	❑
Kneel	❑	❑	❑	❑	❑
Reach Overhead	❑	❑	❑	❑	❑
Bend Forward	❑	❑	❑	❑	❑
Turn Left	❑	❑	❑	❑	❑
Turn Right	❑	❑	❑	❑	❑
Seat to Standing	❑	❑	❑	❑	❑
Sleep	❑	❑	❑	❑	❑
Eat	❑	❑	❑	❑	❑
Go Up/Down Stairs	❑	❑	❑	❑	❑
Get In/Out of Car	❑	❑	❑	❑	❑
Drive	❑	❑	❑	❑	❑
Use Computer	❑	❑	❑	❑	❑
Focus/Concentrate	❑	❑	❑	❑	❑
House Hold Choirs	❑	❑	❑	❑	❑
Lift Children	❑	❑	❑	❑	❑
Carry Bag/Purse	❑	❑	❑	❑	❑
Run/Hike	❑	❑	❑	❑	❑
Sexual Activity	❑	❑	❑	❑	❑
Other: _______________	❑	❑	❑	❑	❑

LIST RESTRICTED ACTIVITY	CURRENT ACTIVITY LEVEL	USUAL ACTIVITY LEVEL
______________________	______________________	______________________
______________________	______________________	______________________
______________________	______________________	______________________
______________________	______________________	______________________
______________________	______________________	______________________

____
Patient or Authorized Person's Signature

______ - ______ - ______
Date Completed

____
Doctor's Signature

______ - ______ - ______
Date Form Reviewed

REVIEW OF SYSTEMS & ORGAN DYSFUNCTION

DIRECTIONS: Check the box(es) that apply to conditions that you or your family members currently have or have had in the past. (Adopted? ❑ No ❑ Yes)

Condition	Current	Past	Never	**Family** (if applicable) Circle: Child/Sibling/Parent/Grandparent
Acid Reflux/Heartburn/GERD	❑	❑	❑	❑ C/S/P/G
ADHD/ADD	❑	❑	❑	❑ C/S/P/G
Allergies	❑	❑	❑	❑ C/S/P/G
Anxiety	❑	❑	❑	❑ C/S/P/G
Arthritis/Joint Pain	❑	❑	❑	❑ C/S/P/G
Asthma/Difficulty Breathing	❑	❑	❑	❑ C/S/P/G
Autism Spectrum	❑	❑	❑	❑ C/S/P/G
Bed Wetting	❑	❑	❑	❑ C/S/P/G
Cancer	❑	❑	❑	❑ C/S/P/G
Carpal Tunnel Syndrome	❑	❑	❑	❑ C/S/P/G
Chest Pain	❑	❑	❑	❑ C/S/P/G
Constipation/Diarrhea	❑	❑	❑	❑ C/S/P/G
Depression	❑	❑	❑	❑ C/S/P/G
Diabetes	❑	❑	❑	❑ C/S/P/G
Difficulty Swallowing	❑	❑	❑	❑ C/S/P/G
Disc Problems	❑	❑	❑	❑ C/S/P/G
Dizziness/Vertigo	❑	❑	❑	❑ C/S/P/G
Eating Disorder	❑	❑	❑	❑ C/S/P/G
Ear Problems/Ringing	❑	❑	❑	❑ C/S/P/G
Epilepsy/Convulsions	❑	❑	❑	❑ C/S/P/G
Fibromyalgia	❑	❑	❑	❑ C/S/P/G
Frequent Illness (Cold/Flu/ect.)	❑	❑	❑	❑ C/S/P/G
Headaches/Migraines	❑	❑	❑	❑ C/S/P/G
Hearing Loss	❑	❑	❑	❑ C/S/P/G
Hemorrhoids	❑	❑	❑	❑ C/S/P/G
High/Low Blood Pressure	❑	❑	❑	❑ C/S/P/G
Infertility	❑	❑	❑	❑ C/S/P/G
Irritable Bowel Syndrome	❑	❑	❑	❑ C/S/P/G
Learning Disability	❑	❑	❑	❑ C/S/P/G
Loss of Balance	❑	❑	❑	❑ C/S/P/G
Menstrual Dysfunction	❑	❑	❑	❑ C/S/P/G
Mid Back Pain	❑	❑	❑	❑ C/S/P/G
Mood Changes/Irritability	❑	❑	❑	❑ C/S/P/G
Numbness/Tingling	❑	❑	❑	❑ C/S/P/G
Pain Coughing or Sneezing	❑	❑	❑	❑ C/S/P/G
Pregnancy (Now)	❑	❑	❑	❑ C/S/P/G
Scoliosis	❑	❑	❑	❑ C/S/P/G
Sinus/Drainage Problems	❑	❑	❑	❑ C/S/P/G
Swelling of Legs/Feet	❑	❑	❑	❑ C/S/P/G
TMJ/Jaw Pain	❑	❑	❑	❑ C/S/P/G
Tremors	❑	❑	❑	❑ C/S/P/G
Trouble Sleeping	❑	❑	❑	❑ C/S/P/G
Vision Problems	❑	❑	❑	❑ C/S/P/G
Organic/System Problems	❑	❑	❑	❑ C/S/P/G

If checked select ALL that apply: ❑ Digestive ❑ Gallbladder ❑ Liver ❑ Stomach ❑ Pancreas ❑ Colon ❑ Reproductive
❑ Lung/Respiratory ❑ Heart ❑ Urinary ❑ Kidney ❑ Prostate ❑ Vision ❑ Thyroid ❑ Skin ❑ Sexual
❑ Other(s): ______________________ Explain: ____

____
Patient or Authorized Person's Signature

_____ - _____ - _____
Date Completed

____

_____ - _____ - _____

Doctor's Signature **Date Form Reviewed**

QUADRUPLE VISUAL ANALOGUE SCALE

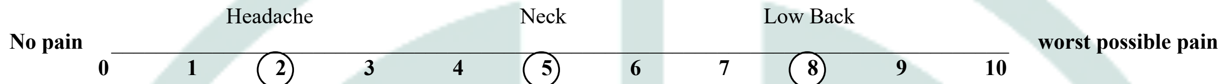
Patient Name ____ Date __________________________

Please read carefully:

Instructions: Please circle the number that best describes the question being asked.

Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

Example:



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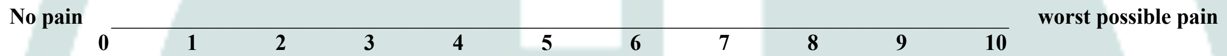
1 – What is your pain RIGHT NOW?



2 – What is your TYPICAL or AVERAGE pain?

3 – What is your pain level AT ITS BEST (How close to "0" does your pain get at its best)?

4 – What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?

OTHER COMMENTS:

____

____

____
Examiner

Reprinted from *Spine*, 18, Von Korff M, Deyo RA, Cherkin D, Barlow SF, Back pain in primary care: Outcomes at 1 year, 855-862, 1993, with permission from Elsevier Science.

TERMS OF ACCEPTANCE

Please read the below and if you have any questions, feel free to ask one of our staff members.

AUTHORIZATION TO CONSENT TO TREATMENT

Dear Parent(s):

State law requires that you consent to most medical treatments for your minor child. If an adult other than your child's parent or legal guardian accompanies him/her to office visits, we will be unable to provide treatment without your written authorization, except in emergency situations. To authorize an adult other than your child's parent or legal guardian to consent to medical treatment for your child, please complete the sections below. By completing this authorization, you consent to the sharing of your child's protected health information with this individual as outlined in our Notice of Privacy Practices.

AUTHORIZATION

I, ______________________________ authorize the following individual(s),
(Name of Parent or Legal Guardian)

Name: ________________________________ Relationship to child: ____________________________

Name: ________________________________ Relationship to child: ____________________________

to consent to medical treatment for my minor child/children listed below:

Name: ________________________________ Date of birth: ____________
Name: ________________________________ Date of birth: ____________
Name: ________________________________ Date of birth: ____________
Name: ________________________________ Date of birth: ____________

LIMITATIONS
Identify any limitation on the kinds of medical services for which this authorization is given. If none are specified, no limitations will be applied.

____
____

Identify any limitations on the time frame for which this authorization is given. If none are specified, no limitations will be applied.

____
____

PARENTAL CONTACT INFORMATION
If the nature of the medical care is not routine, please try to contact me (us) regarding the health care of my (our) children at the following telephone number(s). If you are unable for any reason to contact me (us), you may rely on the proxy decision maker for consent.

Parent's Name: ________________________ Parent's Name: __________________________
Daytime Phone: ________________________ Daytime Phone: __________________________
Evening Phone: ________________________ Evening Phone: __________________________
Cell Phone: ___________________________ Cell Phone: _____________________________

____ ____________
Signature of Parent or Legal Guardian Date

INFORMED CONSENT

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risks are most often minimal, complications such as sprain/strain injuries, irritation of a disc condition, dislocations of joints, and although very rare, fractures, and possible stroke (estimated to be related in one in one million to one in two million cervical adjustments), have been associated with chiropractic adjustments. Treatment objectives, as well as the risks associated with chiropractic adjustments and all other procedures provided at Addasu Family Chiropractic have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

___________________________	___________________________	____/____/____
Patient Name (print)	Patient Signature	Date
___________________________	___________________________	____/____/____
Parent/Authorized Person Name (print)	Parent/Authorized Person Signature	Date
___________________________	___________________________	____/____/____
Witness Name (print)	Witness Signature	Date

AUTHORIZATION FOR X-RAYS

FEMALES ONLY: *Please read carefully, check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our front desk staff for further explanation.*

❑ The first day of my last menstrual cycle was on ____-____-____ (Date)

❑ I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I am not pregnant.

By my signature below, I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration, I therefore do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

___________________________	___________________________	____/____/____
Patient Name (print)	Patient Signature	Date
___________________________	___________________________	____/____/____
Parent/Authorized Person Name (print)	Parent/Authorized Person Signature	Date
___________________________	___________________________	____/____/____
Witness Name (print)	Witness Signature	Date

HIPPA PERSONAL HEALTH INFORMATION RELEASE

I, ___________________________, hereby authorize Addasu Family Chiropractic to discuss with and/or release information to the following people concerning my appointments, insurance, billing, and health treatment rendered.

- ❑ Spouse Name: ___________________________
- ❑ Significant Other Name: ___________________________
- ❑ Parent/Legal Guardian Name: ___________________________
- ❑ Child(ren) Name(s): ___________________________
- ❑ Any Specified Person Name: ___________________________
- ❑ Information is not to be discussed with or released to anyone.

Restrictions:

- ❑ No Restrictions ❑ Only discuss my appointment time with the above-named individual(s).
- ❑ Only discuss issues concerning my account, including insurance and/or billing with the above-named individual(s).
- ❑ Only discuss the health treatment rendered to me with the above-named individual(s).

Messages:

Please call ❑ my home ❑ my work ❑ my cell phone Phone Number: _____ - _____ - _____

If unable to reach me:

- ❑ you may leave a detailed message ❑ please leave a message asking me to return your call
- ❑ ___________________________

I understand I may terminate this consent at any time by giving written notice to Addasu Family Chiropractic. Any changes to this form will require a new consent form to be completed, signed, and dated.

Signature: ___________________________ Date: ___________________

ADASSU FAMILY CHIROPRACTIC NOTICE OF PRIVACY PRACTICE

This office is required, by law, to maintain the privacy and security of your Protected Health Information. We must provide you with written notice concerning your rights to your health information, and the potential circumstances under which, by law, or as dictated by our office policy, we are permitted to use and disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. Please review carefully, sign receipt of acknowledgement, and return to our front desk staff.

YOUR RIGHTS:

1. To inspect or obtain a copy of your records within 15 days of your request. We may charge a reasonable, cost-based fee for a copy. X-rays are original records, and you are therefore not entitled to them. If you would like us to outsource them to have copies made, we will be happy to accommodate you. However, you will be responsible for this cost.
2. To ask for amendments to your health information you think is incomplete or incorrect. We may say “no” to your request, but we’ll tell you why in writing within 60 days.
3. To request confidential communications (contact you in a specific way or send mail to a different address).
4. To request restrictions on certain uses and disclosures, and with whom we release information to, although we are not required to comply. If we do agree, the restriction is in place until receiving written notice of your intent to remove the restriction.
5. To receive an accounting of disclosures (those with whom we’ve shared your information).
6. To receive a paper copy of the extended detail Notice of Privacy Practices.
7. To choose someone to act for you. If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
8. To file a complaint if you feel your rights are violated

USES AND DISCLOSURES:

1. Treatment purposes - use your health information and share it with other health care providers who are treating you.
2. Run our organization - use and share your health information to run our practice, improve your care, and contact you when necessary.
3. Bill for your services - use and share your health information to bill and get payment from health plans or other entities.
4. Inadvertent disclosures – an open treating area means open discussion. If you need to speak privately with the doctor, please let our staff know so we can place you in a private room.
5. Help with public health and safety issues - in order to prevent or lessen a serious or eminent threat to the health or safety of a person or general public.
6. For health research purposes.
7. Comply with the law - share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we’re complying with federal privacy law.
8. Work with a medical examiner or funeral director - share health information with a coroner, medical examiner, or funeral director in the event of a patient’s death.
9. For workers’ compensation claims, law enforcement purposes or with a law enforcement official, and other government requests – including health oversight agencies for activities authorized by law, special government functions such as military, national security, and presidential protective services.
10. Respond to lawsuits and legal actions - share health information about you in response to a court or administrative order, or in response to a subpoena.
11. Emergency – in the event of a medical emergency we may notify a family member.
12. Phone calls and/or emails – we may call your home and leave messages regarding appointment reminders or apprise you of changes in practice hours or upcoming events.
13. Change of ownership - in the event this practice is sold your health information will become the property of the new owner. You maintain the right to request copies of your health information be transferred to another provider.

COMPLAINT: If you wish to make a complaint about how we handle your health information, please contact our Dr. Kevin G. Powell at drkpowell@addasufamilychiropractic OR call (615) 590-9618. If Dr. Powell is unavailable, you may make an appoint with our receptionist to see him within 72 hours or 3 working days. If you are still not satisfied with the manner in which this office handles your complaint, you can submit a formal complaint to: U.S. Dept. of Health and Human Services, Office of Civil Rights | 200 Independence Avenue, SW, Washington DC 20201 | 877-696-6775 | www.hhs.gov/ocr/privacy/hipaa/complaints

___________________________________ ______ - ______ - ______

Patient or Authorized Person’s Signature **Date Completed**

_______________________________________ ______ - ______ - ______

Doctor’s Signature **Date Form Reviewed**

ADASSU FAMILY CHIROPRACTIC NOTICE OF PRIVACY PRACTICE *(CONTINUED)*

I hereby acknowledge I have read and received a copy of Addasu Family Chiropractic Privacy Practices Notice. I understand my rights as well as the practice's duty to protect my health information, and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this "Notice of Privacy Practices" at any time in the future and will make the new provisions effective for all information that it maintains past and present. I am aware the practice will not use or share my information other than as described here unless I have provided written authorization stating otherwise. I understand I may change my mind at any time by providing written notification to the practice. I am aware an extended detail version of this "Notice" is available to me upon request. At this time, I do not have any questions regarding my rights or any of the information I have received.

Signature: ______________________________ Date: ________________

Print Name: ______________________________ Telephone: ________________

If not signed by the patient, please indicate relationship:

_____ Parent or guardian of minor patient
_____ Guardian or conservator of an incompetent patient
_____ Beneficiary or personal representative of deceased patient

Name of Patient: ____

For Office Use Only

Signed form received by: ____

Reason acknowledgment not obtained: ______________________________

Efforts to obtain: ____

PATIENT'S NAME: ______________________ HR#: __________ DATE: ________