GABBERT MEDICAL

PEDIATRIC CHIROPRACTIC INTAKE FORM

Name of Child _____ Date _____

Date of Birth _____ Gender: Male ◯ Female ◯

Name of Parent/Guardian _____ Phone _____

Address _____ City _____ State _____ Zip _____

Email _____ Text Reminders: Yes _____ No _____

Siblings, Name & Ages _____

Reason for today's visit? _____

Who can we thank for your referral? _____

Date of last pediatrician appointment/reason? _____

Any health concerns? _____

Has your child undergone care for any conditions? (please list medications) _____

_____

Birth Location: Home Birth ◯ Birth Center ◯ Hospital ◯ Birth Provider: Midwife ◯ OBGYN ◯

Duration of pregnancy: _____weeks Induced labor ◯ C-Section ◯ Vacuum ◯ Forceps ◯

Birth Weight: _____ Length: _____ Duration of Labor/active labor: _____ APGAR: _____

Any medications during labor/delivery: _____ Is so, what kind: _____

Any complications with birth? _____ If yes, please describe: _____

Was baby alert and responsive within 12 hours of birth? _____ If no, please explain: _____

Do sleeping patterns seem normal to you? _____ If no, please explain: _____

How many wet diapers in a day? _____ How many dirty diapers in a day? _____

What is baby's diet like? (Breastfeeding times, oz of milk, formula, solids, etc.) _____

_____

GABBERT MEDICAL

SINCE THE HEALTH OF THE NERVOUS SYSTEM CAN BE AFFECTED BY MANY TYPES OF STRESSORS, THE FOLLOWING INFORMATION IS VERY IMPORTANT.

CHEMICAL STRESSORS (Childs age may not apply to parts of this section)

Was baby breast fed? Yes ◯ No ◯ For how long? _____

Was formula ever introduced? Yes ◯ No ◯ What age/type of formula? _____

Was there introduction of cow's milk? Yes ◯ No ◯ What age? _____

Food/Juice intolerance? Yes ◯ No ◯ If Yes, what type? _____

Did mother smoke during pregnancy? Yes ◯ No ◯ Did mother drink alcohol? Yes ◯ No ◯

Any illness of mother during pregnancy? Yes ◯ No ◯ Any drugs taken during pregnancy? Yes ◯ No ◯

Any invasive procedures (amniocentesis, CVS?) Yes ◯ No ◯

Was baby vaccinated at birth Yes ◯ No ◯ If yes, which ones? _____

Any reactions to vaccines? Yes ◯ No ◯ If yes, what kind? _____

Any antibiotics since birth? Yes ◯ No ◯ If yes, what kind? _____

PSYCHOSOCIAL STRESSORS (Childs age may not apply to parts of this section)

Any difficulties with nursing? Yes ◯ No ◯ If yes, what kind? _____

Any behavioral problems? Yes ◯ No ◯ If yes, what kind? _____

Any night terrors, sleepwalking, bed wetting? Yes ◯ No ◯ Explain: _____

TRAUMATIC STRESSORS (Childs age may not apply to parts of this section)

Any traumas during pregnancy (falls/accidents) Yes ◯ No ◯ If yes, what kind? _____

Any birth trauma evidence? (bruises, odd shaped head, stuck in birth canal, excessively long birth, respiratory depression, cord around neck, other?) Yes ◯ No ◯ If yes, what kind? _____

Any falls from couches, bed, changing tables? Yes ◯ No ◯ If yes, what kind? _____

Any Hospitalizations? Yes ◯ No ◯ If yes, please explain: _____

Any surgeries? Yes ◯ No ◯ If yes, please explain: _____

Sports played and years began? _____ Hours per week: _____

Weight of school backpack? _____

Has your child ever seen a Chiropractor? Yes ◯ No ◯ Name of Chiropractor _____

MILESTONES (Circle all those that apply please)

1-3 MONTHS:

	Supports head and upper body when on stomach?		Stretches out legs and kicks when on back or stomach?
	Opens and shuts hands?		Grabs and shakes toys?
	Follows moving objects with eyes?		Turns head to sound of stimulus?
	Makes cooing sounds?		Smiles at familiar faces?

4-7 MONTHS:

	Rolls over both stomach to back & back to stomach?		Sits up with/without support?
	Reaches for objects?		Transfers objects from hand to hand?
	Supports whole weight standing?		Explores objects with hands and mouth?
	Laughs?		Babbles consonants?

8-12 MONTHS:

	Gets in and out of sitting position independently?		Gets on hands and knees position to crawl?
	Pulls self up to standing/walks along furniture?		Holding spoon or book by themselves?
	Says "mama" and "dada" referring to parent?		

Gabbert Chiropractic & Pain Treatment Center is in accordance with Arizona State Law maintains medical records for a period of at least six (6) years after the last treatment date. Minor patient's records are maintained for a period of at least three (3) years after the child's 18th birthday or for at least six (6) years after the last treatment date, whichever occurs later. Gabbert Chiropractic & Pain Treatment Center has a protocol for the secure storage, transfer, disposal and access of medical records at our office. By singing below I acknowledge that I have been provided a copy of the ***Medical Records Protocol*** for Gabbert Chiropractic & Pain Treatment Center and is available to me at any time upon request.

RECORD RELEASE

I understand that my records and X-Rays may be released for professional consultations to other health providers as necessary. Gabbert Chiropractic & Pain Treatment Center routinely sends many X-Rays and related health care information to Diagnostic X-Ray Consultation Services for interpretation. Should additional consultations be required with other HealthCare providers (i.e. Orthopedists, Neurologist, etc.) records will be provided as necessary. I also understand that my records and X-Rays may be released for payment purposes to Insurance Companies, Attorneys, and/or other third parties as necessary to obtain payment. By singing below I authorize the release of my records and X-Rays for these purposes. I understand that all my records will be kept confidential and will not be released without my written consent.

NOTICE OF PRIVACY PRACTICES

Gabbert Chiropractic & Pain Treatment Center in accordance with HIPAA regulations wants to protect your rights and privacy as a patient. In addition, we will <u>not</u> provide your medical records to any outside third party for independent marketing purposes. All medical records are stored in compliance with Arizona State Law. Any questions regarding Privacy Practices may be directed to the Chief of Staff, Dr. Brian Gabbert who serves as the Privacy Officer. By signing below I acknowledge that I have been provided a copy of the ***Notice of Privacy Practices*** for Gabbert Chiropractic & Pain Treatment Center (PP-09-23-13) and is available to me at any time upon request and in no way affects the care I receive at Gabbert Chiropractic & Pain Treatment Center.

By signing below I authorize Gabbert Chiropractic & Pain Treatment Center to provide such care.

Patient Print Name: _____ Date: _____

Patient Signature: _____

Parent/Guardian Signature required if patient is under the age of 18.

Gabbert Medical
903 E Hwy 260, Suite 4 | Payson, Az 85541
P: 928-472-2225 | **F:** 928-468-0002
www.Gabbertcc.com

OFFICE POLICIES

OFFICE HOURS

Our office is open Monday-Thursday 9:00 am to 6:00 pm and Friday 9:00 am to 1:00 pm. Patients are not scheduled from 1:00 pm through 2:00 pm during lunch. We are closed in observance of all major holidays.

NEW PATIENTS

For purposes of maintaining continuity of care, we ask that first time patients bring us the latest relevant records with the most recent test results, MRI / CT / XRAY/BLOOD WORK and current medications list. We do ask that you remain the sole custodian of your entire medical records from your previous healthcare providers. Should there be a need to further examine your previous records; our providers will have you bring your records back for additional review during subsequent office visits.

COURTESY

We strive to provide the best medical care for our patients. While we make every effort to provide prompt on-time service, the healthcare needs of each individual do not necessarily lend themselves to an exact schedule. We therefore appreciate your understanding and patience if you have to wait a few extra minutes. If you have any suggestions or complaints for our office, please let us know. Angry or foul language directed to our staff regardless of the issues involved will absolutely not be tolerated and will be grounds for immediate dismissal from our practice.

SUPERVISION OF CHILDREN & MINORS PRESENT WITHOUT PARENTS OR LEGAL GUARDIAN

Although we provide an area for children to entertain themselves, for safety reasons, we depend on parents to properly supervise their child(ren) at all times. Our staff cannot watch your children. Under no circumstances should a child under the age of 10 be left unattended. We also require a consent form signed by a parent or legal guardian to legally provide medical care to minors 16 and 17 years of age when the parent or legal guardian cannot be present. Minors 15 years of age or younger must be accompanied by a parent or legal guardian.

CHANGES IN ADDRESS, BILLING, OR CONTACT INFORMATION

Please notify our office in writing of any changes of address, telephone, billing or contact information. It is imperative that we have the most current information on file.

FEES & PAYMENTS

Prices/Fees are subject to change. Payment in full is due at the time services are rendered. We do not except any forms of insurance. We accept credit/ debit cards, cash, personal check, cashier's checks, HSA cards. A copy of your driver's license or photo ID will be taken for your file on record. Should you require a payment plan, our office manager will be glad to discuss your options with you.

Balances over 120 DAYS due may be sent to a collection agency unless other arrangements have been made. A $50 fee may be assessed on accounts placed in collections. We may also elect to discharge you from our practice should you fail to comply with our policy.

APPOINTMENTS AND NO SHOW

We make every effort to provide prompt medical care to all of our patients. If you are unable to keep a scheduled appointment, please let us know at least 24 hours in advance. A NO SHOW is when a patient fails to keep a scheduled appointment and does not give an appropriate amount of notice time. If you are scheduled for IV and or Injection therapy and no show, a fee may be assessed to cover the cost of wasted product if the IV or injection was pre-made. Fees will be assessed as follows, IV-$100.00 / Injection-$20.00 In the event that you have a special circumstance regarding your missed appointment, please contact our office manager. We understand that there may be issues beyond your control and want to be understanding of special circumstances.

If you are delayed and cannot make an appointment on time, please call to advise us of your situation and provide an estimated time of arrival. Any significant delay may require the visit to be rescheduled.

Should you have more medical issues that need to be addressed, please inform our staff when calling for appointments, and we will schedule more time for you accordingly. Multiple family member appointments must be scheduled in advance. Family members who are present at the time of another member's appointment, but are not scheduled, may be required to schedule an appointment at a later time.

TELEPHONE MESSAGES & PROCESSING OF REFERRALS

We will try our best to respond to your messages as soon as possible. However, please be aware that messages may take up to 24 HOURS to process and respond. More often than not, if your questions require extensive attention, the doctor may elect to have you make an appointment and come for further evaluation for quality assurance purposes.

MEDICAL RECORDS & FORMS

All requests for medical records must be on a HIPPA approved form, which must be properly and completely filled out and signed by the patient or legal guardian. Improperly filled out forms may delay your request. Please allow at least 10 BUSINESS DAYS for processing.

Medical records released to a new provider, specialist or school: For continuity of care and as a courtesy to the patient, our office will forward records requested at no charge.

Medical records released to the patient, some insurance companies, law firm or miscellaneous requests: Records are subject to copying fees.

IN A LIFE THREATENING SITUATION, PLEASE CALL 911 IMMEDIATELY.

Our friendly staff is committed to making your visit as pleasant as possible. Your comments or concerns are important to us. We rely on them to continue to improve our quality medical care to you and your family.

By signing below, I understand and agree to the office policies and procedures explained above. A copy of the office policies and procedures along with notice of privacy information regarding Gabbert Chiropractic & Pain Treatment Center will be available to me upon request.

Patient Print Name: _____ Date: _____

Patient Signature: _____

Parent/Guardian Signature required if patient is under the age of 18.