NEW PATIENT CHILD HEALTH HISTORY

Two options for completing this form:
Please fill out on your computer, print it, and bring it to your first appointment.

Please print out this form, then fill it out using a pen, and bring it to your first appointment.

Note: Regardless of the completion method selected above, the diagrams on page three and signatures on pages two, three and five require you to use a pen to complete them. If you email us the form, this can be done in our office.

Patient Contact Information

Child's Name: ____ Nickname: ______________________________ DOB: __________________: Age: ________

M/F: _____________ Current Diagnosis: ____

Address: ____ Apt (if applicable) _____________

City: ____ State: _____________ Zip Code: ______________________

Primary Phone: ____ Preferred E-mail: ____

Child's School: ____ Grade: _______________________

Parent/Guardian Contact Information

Parent #1 Name: ____ DOB: ________________ Occupation: ______________________________

Home Phone: _________________________________ Cell Phone: __________________________________ Work Phone: ____________________________

SSN: ____ Marital Status: M S W D (please circle one)

Parent #2 Name: ____ DOB: ________________ Occupation: ______________________________

Home Phone: _________________________________ Cell Phone: __________________________________ Work Phone: ____________________________

SSN: ____ Marital Status: M S W D (please circle one)

Emergency Contact: ____ Relationship: ______________________ Phone: ______________________

Primary Language: ____ Language(s) spoken at home: ______________________________________

Child's Primary Physician: ____ Address and Phone: ____

Insurance Information

Primary Insurance: ____ Secondary Insurance: ____

Subscriber: ____ Subscriber: ____

Subscriber DOB: ____ Subscriber DOB: ____

Relationship to child: ____ Relationship to child: ____

Contract/ID#: ____ Contract/ID#: ____

Group#: ____ Group#: ____

Employer: ____ Employer: ____

I, ____, hereby give my consent for FUNctional Kids Therapy Center LLC to bill my/charge my child's insurance carrier for the services rendered to me/my child/ family by the above mentioned provider. In addition, I agree to pay FUNctional Kids Therapy Center LLC any remaining fees or uncovered charges in accordance with my health care plan.

____ ____ __________________

Parent/Guardian Signature   Relationship to client   Date

Medical History

Prenatal & Birth History

Full-term	☐ Yes ☐ No
Premature	☐ Yes ☐ No If yes, how many weeks gestation?
Low birth weight	☐ Yes ☐ No
Birth weight	____lb(s)____oz
Breech birth	☐ Yes ☐ No
Type of delivery	☐ C-section ☐ Vaginal If C-section, was it an emergency? ☐ Yes ☐ No
Forceps assisted	☐ Yes ☐ No
Vacuum assisted	☐ Yes ☐ No
Preeclampsia	☐ Yes ☐ No
Gestational diabetes	☐ Yes ☐ No
Multiple ultrasounds	☐ Yes ☐ No
Oxygen deprivation	☐ Yes ☐ No
NICU stay	☐ Yes ☐ No If yes, what was the duration?

Medical & Developmental History

Jaundice	☐ Yes ☐ No
Breast fed	☐ Yes ☐ No
Formula fed	☐ Yes ☐ No
Poor suction/latch	☐ Yes ☐ No
Chronic ear infections	☐ Yes ☐ No
Tubes	☐ Yes ☐ No
Tonsils/adenoids surgery	☐ Yes ☐ No
Acid reflux	☐ Yes ☐ No
Poor weight gain	☐ Yes ☐ No
Feeding problems/picky eating	☐ Yes ☐ No
Tongue or lip tie	☐ Yes ☐ No
Colic	☐ Yes ☐ No
Sleeping problems	☐ Yes ☐ No
Asthma	☐ Yes ☐ No
Cardiac issues	☐ Yes ☐ No
Frequent antibiotic use	☐ Yes ☐ No
Frequent fevers	☐ Yes ☐ No
Abnormal muscle tone	☐ Yes ☐ No
Vision problems	☐ Yes ☐ No
Compromised immune system	☐ Yes ☐ No
Headaches	☐ Yes ☐ No
Abnormal lab results	☐ Yes ☐ No
Hearing problems/evaluation	☐ Yes ☐ No
Allergies	☐ Yes ☐ No
Wetting	☐ Yes ☐ No If yes, day or night?

Check the statement that best describes your child:

☐ Didn't like tummy time OR ☐ Loved being on belly
☐ Met all motor milestones on time OR ☐ Was/is developmentally delayed
☐ Is clumsy OR ☐ Has always seemed athletic
☐ Struggles with use of hands/fine motor OR ☐ Uses utensils and pencils easily
☐ Avoids climbing, swinging, being upside down OR ☐ Seems to crave/love movement

When did your child do the following?

Skill	***Age (months)***
Sat up	
Rolled over	
Pulled up to stand	
Belly crawled	
Hands and knees crawled	
Walked	
Spoke first word	
Spoke in sentences	

My child communicates using:

☐ is non-verbal
☐ single words
☐ 2-3 word phrases
☐ sentences

Medical History Continued

Current weight: ___________________________ Current height: __________________________

Medications your child is currently taking:

Pharmaceutical Medication	Treatment	Dosage

Supplements your child is currently taking:

Vitamins/Mineral/Herbs/Supplements	Treatment	Dosage

Reasons for Seeking Care

Chief Complaint (include location) ____

Rate Intensity (0 = No Pain/Symptoms, 10 = Worst Possible Pain/Symptoms) ❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑10

Secondary Complaint, if any (include location) ____

Rate Intensity (0 = No Pain/Symptoms, 10 = Worst Possible Pain/Symptoms) ❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑10

Complaint(s) Began When & How? ____

Description of the Complaint/Pain: ❑ Dull ❑ Aching ❑ Sharp ❑ Shooting ❑ Burning ❑ Throbbing ❑ Deep ❑ Nagging
❑ Other Describe ____

Does This Pain Radiate or Travel (Shoot) to Any Other Areas of Your Body? ❑ Yes ❑ No If Yes, Where? _______________________

Do You Have Any Numbness or Tingling in Your Body? ❑ Yes ❑ No If Yes, Where? _______________________________________

How Frequent Is Complaint Present, How Long Does It Last?____

Does Anything Aggravate the Pain? ____

Does Anything Make the Pain Better? ____

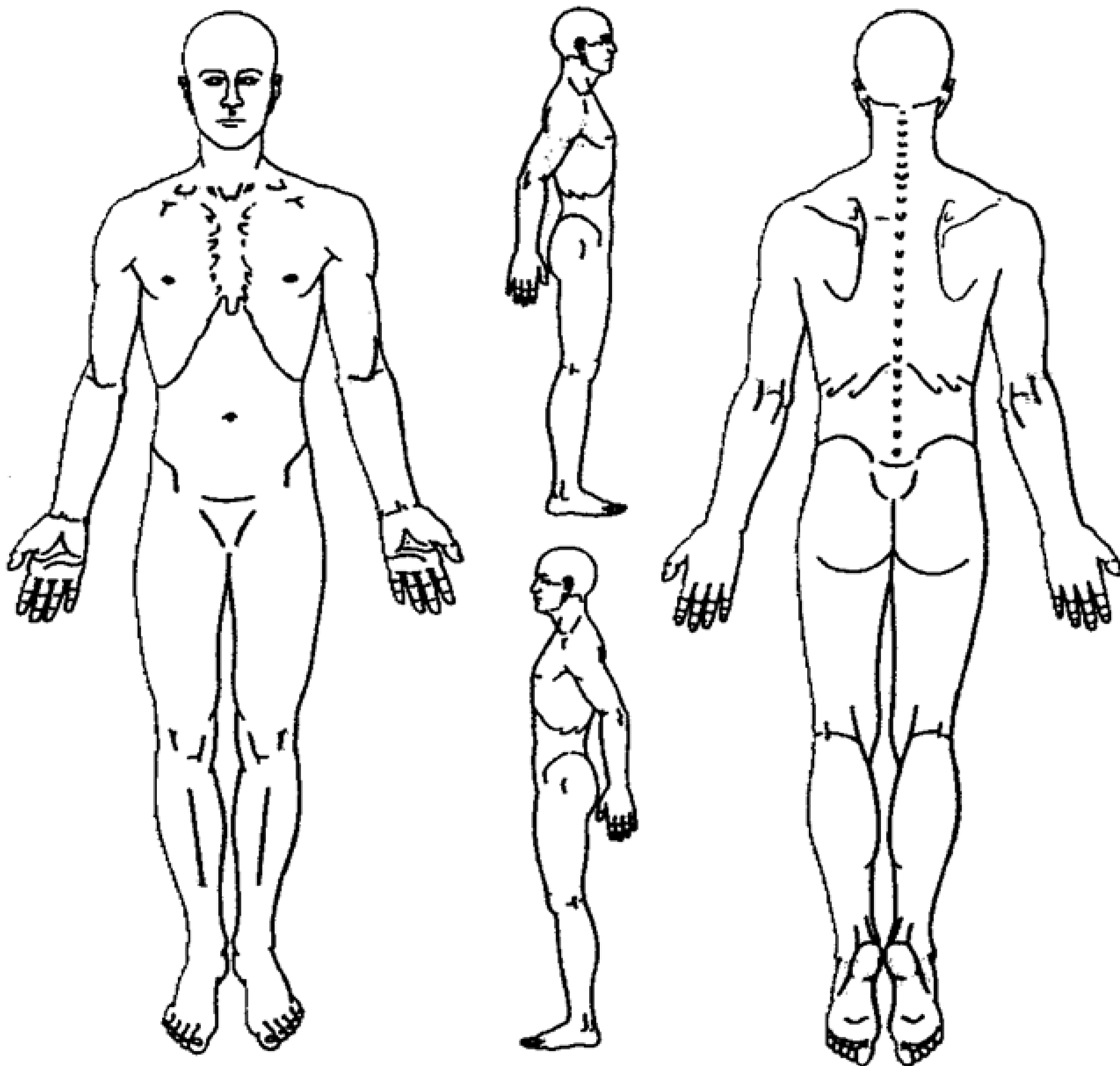
Has your child ever seen a chiropractor before? Y / N If yes, for what reason: ____

Chiropractic Diagram

- Please print this diagram and complete with a pen

Using the Letters Below, Mark the Areas of the Diagram to Indicate Where You Feel the Following Sensations:

A = Aches **B** = Burning **N** = Numbness **P** = Pins & Needles **S** = Stabbing **O** = Other



FUNctional Kids Parent/Guardian Conduct Policy

By signing below all guardians and parents are agreeing to adhere to the **FUNctional Kids** Conduct Policy which prohibits the use of any and all negative behaviors to intimidate, harass, belittle or threaten staff members in this place of business. Any violations with the above mentioned behaviors are grounds for immediate dismissal from therapy services. Be advised that any extreme situation experienced by a staff member can be immediately reported to the local authorities and your child's care will be immediately terminated from our practice without verbal or written advanced warning.

Parent /Guardian signature:____Date: _______________________

FUNctional Kids Financial Policy

You are responsible for knowing your benefits outlined in your specific insurance plan including your co-insurance, co-pay, and deductible amounts if applicable. Please be advised that some insurance providers do not cover chiropractic care. Functional Kids Therapy Center LLC is NOT responsible for these costs that are dictated by your insurance carrier and if coverage is denied you will be responsible for payment of care, including any evaluations.

Should you be delinquent in paying your bill past 3 months and have not made arrangements for a payment schedule, you are legally responsible for the amount outlined by your insurance carrier and will be sent to collections if the account goes unpaid. You are responsible for any finance charges & fees **Functional Kids Therapy Center LLC** incurs in collecting therapy service fees from you including legal costs for actions that may be needed to collect on your account(s).

My signature below is confirmation that I have been informed of and agree to the insurance policy of **FUNctional Kids Therapy Center LLC.**

Parent/Guardian signature: ____ Date: _________________________

Notice of Video and Audio Recordings

Functional Kids Therapy Center prides itself on being a safe, inclusive environment for children and families of various backgrounds and needs. To ensure that we are maintaining a safe and inclusive environment, we have decided to add security features to our Battle Creek and Caledonia, Michigan locations, including video and audio recording devices. We have added these devices to main areas of the facilities, such as the waiting rooms and certain exist/ entry points. We value our patients' privacy and we can assure our patients that the recording devices are not located in any private bathrooms or examination rooms. We have posted notices around the facilities to notify our patients of these added security features. As the video and audio recording devices will record protected health information (PHI) and such PHI will be stored electronically (ePHI), please be assured that we have implemented and will utilize these security features in accordance with the provisions of the Health Insurance Portability and Accountability Act (HIPAA) and the HIPAA Policies and Procedures of **Functional Kids Therapy Center, L.L.C.** We maintain appropriate administrative, technical and physical safeguards to ensure the confidentiality and integrity of any PHI and ePHI collected via any video and audio recordings and to protect against any breach or unauthorized use or disclosure of such information. We have also properly trained our workforce with respect to HIPAA rules and regulations as well as the use of these video and audio recording devices. **These devices are secure, closed circuit, password protected accounts that are NOT shared with the public.** We will only disclose video footage or audio recordings as requested by health care providers for treatment purposes, as expressly authorized by patients or as required by law.

By signing below, you acknowledge that **FUNctional Kids Therapy Center LLC** has implemented audio and video recordings on our premises and you authorize us to conduct such recordings.

Signature of Parent/Guardian:____Date: __________________________

Printed Name of Parent/Guardian: ____

FUNctional Kids Attendance Policy

FUNctional Kids Therapy Center LLC wants to improve your child's quality of life through consistent and high quality care. Cancellations, especially those with less than 24 hour notice including no-call/no-shows limit your child's progress and our ability to care for others. Please call the Caledonia location at (616) 536-2211 if you need to cancel or reschedule an appointment. We ask for your full cooperation with the following policy:

* If you are unable to keep your scheduled appointment, we request that you notify us immediately so that your appointment can be rescheduled and another patient may take your slot - there is an after hours answering machine for weekends. **You must cancel by noon the previous business day to avoid a $25 cancellation fee (not payable by insurance).**
* Greater than 50% cancellation in a 30 day period will also result in loss of preferred afternoon or early morning time slot(s) until further consistent attendance is established.
* **If you do not show up to a scheduled appointment, a $50 no-show fee will be added to your account and must be paid before resuming therapy (not payable by insurance).** All cancellations and no-shows will be documented in your medical record and appropriately reported to your physician and insurance/third party payer.
* If you accumulate two no-shows this will result in an automatic discharge.
* If you are more than 15 minutes late for your appointment and you do not call the office you will be considered a no-show and will be charged $50 and dismissed from the practice.

We believe that this policy is necessary for the benefit of all patients, so that we can continue to provide high-quality treatment and service to everyone. If you should have any questions regarding this policy, please feel free to discuss them with your therapist.
My signature below is confirmation that I have been informed of and agree to the attendance policy of **FUNctional Kids Therapy Center LLC.**

Parent/guardian signature: ____ Date:_______________________

General Consent For Treatment

GENERAL RELEASE

Regardless of any limitation set forth above, I understand and acknowledge that **Functional Kids Therapy Center** is permitted to make uses and disclosures of my health information for purposes of treatment, payment and health care operations.

I understand that the failure to sign/submit this authorization or the cancellation of this authorization will not prevent me from receiving any treatment or benefits that I am entitled to receive, provided this information is not required to determine if I am eligible to receive those treatments or benefits or to pay for the services I receive.

I understand that this information cannot be exchanged without my written consent and hereby give approval as outlines above.

Printed Name of Parent/guardian : ____

Signature of Parent/guardian: ______________________________________Date: ______________

Consent Form

Photograph/Video Professional Services

I hereby give my consent for **Functional Kids Therapy Center** to use and disclose the professional images/video taken during therapeutic interactions with my child(ren) and the staff at Functional Kids Therapy Center LLC.

With this consent, **Functional Kids Therapy Center** may use these professional images and/or video for the creation of various promotional and marketing materials to promote other professional services to families and community members. This may include but is not limited to dissemination of materials to: other licensed health care professionals, teachers, parents, grandparents, chiropractors, physicians, nurses and any other allied health providers.

With this consent, **Functional Kids Therapy Center** may place this professional video/photo content on their website, Instagram or Facebook page. By signing below, I give Functional Kids permission to disclose what services that my child is receiving in the promotional materials and use their first name in the dialogue to better explain and promote the therapeutic services they are being shown to be participating.

By signing this form, I am consenting to allow **Functional Kids Therapy Center** to use and this imagery and understand that it will be used only for professional services to market and promote the services of the organization

Guardian/Parent Signature:____________________________________Date: _____________________

AUTHORIZATION FOR ELECTRONIC COMMUNICATION

I consent to the use of electronic communication (which may include a link to an online portal) to contact me as needed. I understand that my service provider may charge me for such communication and also that electronic communication, while very convenient, may not always be very secure.

I authorize to be contacted via text-message at ______________________________________
I authorize to be contacted via electronic mail at _____________________________________

☐ I prefer to be only contacted via US Mail and telephone number on file.