



## New Pediatric Practice Member Intake Form

First Name: \_\_\_\_\_  
 Last Name: \_\_\_\_\_  
 Nickname: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_  
 State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
 Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Sex: ( ) Male ( ) Female  
 Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
 Mothers Name: \_\_\_\_\_  
 Fathers Name: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_  
 Work Phone: \_\_\_\_\_  
 Cell Phone: \_\_\_\_\_

Insurance: ( ) Work Comp ( ) Auto ( ) MA  
 ( ) Medicare ( ) Private: \_\_\_\_\_  
 Whom may we thank for referring you to our  
 office? \_\_\_\_\_  
 How were you referred to our office?  
 ( ) Yellow pages ( ) Lecture ( ) Drive by  
 ( ) Coupon ( ) Screening Where? \_\_\_\_\_  
 \_\_\_\_\_  
 ( ) Mailing = which one? \_\_\_\_\_  
 ( ) Other: \_\_\_\_\_

In case of an emergency, please contact:  
 Name: \_\_\_\_\_  
 Phone: \_\_\_\_\_  
 Relationship: \_\_\_\_\_

## Your Child's Health Profile

Please rate your overall health status of your child:

Poor 1 2 3 4 5 6 7 8 9 10 Excellent

What are your health objectives for your child? \_\_\_\_\_  
 \_\_\_\_\_

Name/Address/Phone of the last doctor who put your child on a health development program?  
 \_\_\_\_\_

Were you able to keep your child on that program? Y N How long? \_\_\_\_\_

What were the results? \_\_\_\_\_

Describe your child's health trend: Better Worse Same Not Sure

If better, what did you do to improve your child's health? \_\_\_\_\_  
 \_\_\_\_\_

If worse, why do you think your child's health declined? \_\_\_\_\_  
 \_\_\_\_\_



**Discover Chiropractic:**  
**A Creating Wellness**  
**Centre**

Dr. Christopher C. Cox, DC  
 Dr. Aaron A. Dingman, DC  
 7290 E. Broadway Blvd Suite 124  
 Tucson, AZ 85710  
 520-731-9595

Doctor Initials: \_\_\_\_\_

Dr. Dustin L. Behn, DC  
 3662 W. Ina Rd. Suite 180  
 Tucson, AZ 85741  
 520-744-1788

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

Will your child be healthier 5 years from now than they are today?      Y      N      Not Sure

If so, what are you planning to do to improve your child's health and if not, what could you do to improve their health rather than have it continue to decline? \_\_\_\_\_

After making these changes in your child's life, how do you expect their health to be 5 years from now? \_\_\_\_\_

Have your child had previous chiropractic care?   Y      N

If yes, what was the doctor's name? \_\_\_\_\_

What was the approximate date of the last visit? \_\_\_\_\_

What was the duration of their care? \_\_\_\_\_

Were you aware that:

- Doctors of Chiropractic work with the nervous system?      \_\_\_Yes    \_\_\_No
- The nervous system controls all bodily functions and systems?      \_\_\_Yes    \_\_\_No
- Chiropractic is the largest natural healing profession in this world?      \_\_\_Yes    \_\_\_No
- If Chiropractic care starts at birth, you can achieve a higher level of health throughout life?      \_\_\_Yes    \_\_\_No

What other wellness professionals are currently a part of your child's health care team?

- Massage Therapist     Acupuncturist     Naturopath     Homeopath
- Other: \_\_\_\_\_

How many Medical Doctor's office visits did your child have last year?

- None     Less than 5     More than 5     More than 10

Is the current condition the result of a **recent**:     auto accident?     work related injury

What was the date of injury? \_\_\_\_\_

If so, please inform the front desk staff immediately to obtain additional necessary paperwork.



Patient Name \_\_\_\_\_ Date \_\_\_\_\_

**Please describe below, in the following 2 sections, your child’s primary, secondary and additional reasons, if any, for seeking care in our office:**

**Primary Complaint** (List one only): \_\_\_\_\_

When did your child first experience this problem? \_\_\_\_\_

How did this problem first begin? \_\_\_\_\_

How often does your child experience this problem?  1-2x/week  3-4x/week  5-6x/week  
 daily  other: \_\_\_\_\_

Please grade the intensity of this problem (with 10 being worst):

At best 1 2 3 4 5 6 7 8 9 10

At worst 1 2 3 4 5 6 7 8 9 10

How does your child describe the symptoms (i.e. burning, stabbing, aching, sharp, etc.)?

\_\_\_\_\_

Please describe the location of the pain. \_\_\_\_\_

\_\_\_\_\_

Does this problem cause pain to travel to any other area? Y N If yes, where? \_\_\_\_\_

\_\_\_\_\_

Is this problem getting:  worse?  better?  staying the same?

What seems to aggravate this problem? \_\_\_\_\_

What have you tried to relieve this problem (i.e. interventions, treatments, aspirin, medications, surgery)? \_\_\_\_\_

\_\_\_\_\_

Have you seen any other doctors for this problem? Y N If yes, who? \_\_\_\_\_

\_\_\_\_\_

What treatment was given? \_\_\_\_\_

How effective was the care? \_\_\_\_\_



Patient Name \_\_\_\_\_ Date \_\_\_\_\_

**Secondary Complaint -- if any** (List one only): \_\_\_\_\_

When did your child first experience this problem? \_\_\_\_\_

How did this problem first begin? \_\_\_\_\_

How often does your child experience this problem?  1-2x/week  3-4x/week  5-6x/week  
 daily  other: \_\_\_\_\_

Please grade the intensity of this problem (with 10 being worst):

At best 1 2 3 4 5 6 7 8 9 10

At worst 1 2 3 4 5 6 7 8 9 10

How does your child describe the symptoms (i.e. burning, stabbing, aching, sharp, etc.)? \_\_\_\_\_

Please describe the location of the pain. \_\_\_\_\_

Does this problem cause pain to travel to any other area? Y N If yes, where? \_\_\_\_\_

Is this problem getting:  worse?  better?  staying the same?

What seems to aggravate this problem? \_\_\_\_\_

What have you tried to relieve this problem (i.e. interventions, treatments, aspirin, medications, surgery)? \_\_\_\_\_

Have you seen any other doctors for this problem? Y N If yes, who? \_\_\_\_\_

What treatment was given? \_\_\_\_\_

How effective was the care? \_\_\_\_\_



Patient Name \_\_\_\_\_ Date \_\_\_\_\_

## **Lifestyle/Social History**

Recreational Activities: \_\_\_\_\_

How much television (including video games) does your child watch per day? \_\_\_\_\_

Does your child drink water regularly?    Y        N        If yes, how much? \_\_\_\_\_

How often does your child exercise or participate in strenuous activities/play?

( ) daily        ( ) \_\_\_x/week        ( ) occasionally        ( ) never

How many hours of sleep does your child get on average? \_\_\_\_\_

Is your child involved in any impact activities (i.e. soccer, football, skateboarding, wrestling, gymnastics, cheerleading, martial arts, hockey, etc.)?    Y        N        If yes, please list: \_\_\_\_\_

On a scale of 1-10 please rate your child's stress level (1 = low and 10 = high): \_\_\_\_\_

## **Parental Information**

Mother's Occupation: \_\_\_\_\_

Father's Occupation: \_\_\_\_\_

Does either parent smoke?        Y        N        If yes, how much? \_\_\_\_\_

On a scale of 1-10 please rate the mothers stress level (1 = low and 10 = high):

Occupational        \_\_\_\_\_

Personal             \_\_\_\_\_

On a scale of 1-10 please rate the fathers stress level (1 = low and 10 = high):

Occupational        \_\_\_\_\_

Personal             \_\_\_\_\_

Doctors Initials: \_\_\_\_\_



Patient Name \_\_\_\_\_ Date \_\_\_\_\_

## Medical History

**Prenatal History:**

Name of Obstetrician or Midwife (please circle which one): \_\_\_\_\_  
 Location of birth:   Hospital       Birth Center       Home  
 Birth Interventions:   Forceps       Vacuum Extraction   C-Section       Epidural  
 Complications during delivery?   Y    N    If yes, what? \_\_\_\_\_  
 Birth Weight: \_\_\_\_\_   Birth Length: \_\_\_\_\_   APGAR Scores: \_\_\_\_\_  
 Complications during pregnancy?   Y    N    If yes, what? \_\_\_\_\_  
 Ultrasounds during pregnancy?   Y    N    If yes, how many? \_\_\_\_\_  
 Medications during pregnancy?   Y    N    If yes, please list: \_\_\_\_\_  
 Rhogam shot?                           Y    N    Smoking during pregnancy?   Y    N  
 Alcohol use during pregnancy?   Y    N

Is your child vaccinated?           Y    N    Vaccination History (age of first vaccination, etc.): \_\_\_\_\_

Was your child breast fed?       Y    N  
 If yes, how long? \_\_\_\_\_  
 If no, what formula? \_\_\_\_\_   How long? \_\_\_\_\_

At what age were solids introduced at? \_\_\_\_\_

At what age was milk introduced at? \_\_\_\_\_

Does your child have any food or juice allergies?   Y    N    If yes, what? \_\_\_\_\_

Number of doses of antibiotics your child has taken: \_\_\_\_\_ During the last 6 months: \_\_\_\_\_

Number of doses of other prescription medications that your child has taken: \_\_\_\_\_  
 During the last 6 months: \_\_\_\_\_

**Surgeries:**

Date	Type	Reason for surgery
_____	_____	_____
_____	_____	_____
_____	_____	_____

Previous injuries or trauma (please give type and date): \_\_\_\_\_



Patient Name \_\_\_\_\_ Date \_\_\_\_\_

Medications that your child is currently taking (including over the counter drugs):

Medication & Dosage	Reason for taking
_____	_____
_____	_____
_____	_____
_____	_____

Nutritional Supplements that your child is currently taking:

Supplement & Dosage	Reason for taking
_____	_____
_____	_____
_____	_____
_____	_____

## Stress History

Please indicate whether you have **ever** experienced stress in any of the following areas. Your answers will enable us to determine which factors have contributed to your present health condition/concerns.

### Childhood

Repeated/Prolonged Antibiotic Use	Y	N	Inhaler Use	Y	N
Car Accident	Y	N	Prescription Medications	Y	N
Childhood Illness	Y	N	Surgery	Y	N
Fall/Jump from a Height < 3 feet	Y	N	Vaccinations	Y	N
Fall/Jump from a Height > 3 feet	Y	N	Youth Sports	Y	N
Head Trauma	Y	N	Other Traumas (physical or emotional) _____		

### Adulthood

Alcohol Consumption	Y	N	Inhaler Use	Y	N
Repeated/Prolonged Antibiotic Use	Y	N	Prescription Medications	Y	N
Car Accident	Y	N	Smoker	Y	N
Coffee Drinker	Y	N	Surgery	Y	N
Drug Use/Abuse	Y	N	Contact Sports	Y	N
Fall/Jump from a Height	Y	N	Extreme Sports	Y	N
Head Trauma	Y	N	Workplace Stress	Y	N
Home Environment Stress	Y	N	Other Traumas (physical or emotional) _____		



Patient Name \_\_\_\_\_ Date \_\_\_\_\_

**Please check any of the following your child has had in the last 12 months and/or ever received treatment for:**

**MUSCULO-SKELETAL**

- Low Back Pain       Pain Between Shoulders       Neck Pain       Arm Pain  
 Joint Pain/Stiffness       Walking Problems       Difficult Chewing/Clicking Jaw  
 General Stiffness

Symptom	Date Last Experienced	Treatment Received
_____	_____	_____
_____	_____	_____
_____	_____	_____

**GENITO-URINARY**

- Painful/Excessive Urination       Discolored Urine       Bladder Trouble

Symptom	Date Last Experienced	Treatment Received
_____	_____	_____
_____	_____	_____

**CARDIO-VASCULAR- RESPIRATORY**

- Chest Pain       Short Breath       Blood Pressure Problems  
 Irregular Heartbeat       Heart Problems       Lung Problems/Congestion  
 Varicose Veins       Ankle Swelling       Stroke

Symptom	Date Last Experienced	Treatment Received
_____	_____	_____
_____	_____	_____
_____	_____	_____

**NERVOUS SYSTEM**

- Nervous       Numbness       Paralysis       Dizziness  
 Forgetfulness       Confusion/Depression       Fainting       Convulsions  
 Cold/Tingling Extremities       Stress       Hearing Difficulty

Symptom	Date Last Experienced	Treatment Received
_____	_____	_____
_____	_____	_____



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Patient Name \_\_\_\_\_ Date \_\_\_\_\_

**EYES, EARS, NOSE, THROAT**

\_\_\_ Vision Problems  
 \_\_\_ Ear Aches

\_\_\_ Dental Problems  
 \_\_\_ Stuffed Nose

\_\_\_ Sore Throat

Symptom	Date Last Experienced	Treatment Received
_____	_____	_____
_____	_____	_____

**GENERAL**

\_\_\_ Fatigue

\_\_\_ Allergies

\_\_\_ Headaches

\_\_\_ Fever

Symptom	Date Last Experienced	Treatment Received
_____	_____	_____
_____	_____	_____

**MALE / FEMALE**

\_\_\_ Menstrual Irregularity  
 \_\_\_ Breast Pain/Lumps

\_\_\_ Menstrual Cramps  
 \_\_\_ Prostate/Sexual Dysfunction

\_\_\_ Vaginal Pain/Infection  
 \_\_\_ Other: \_\_\_\_\_

Symptom	Date Last Experienced	Treatment Received
_____	_____	_____
_____	_____	_____

**GASTRO-INTESTINAL**

\_\_\_ Poor/Excessive Appetite  
 \_\_\_ Vomiting  
 \_\_\_ Hemorrhoids  
 \_\_\_ Weight Trouble  
 \_\_\_ Heartburn

\_\_\_ Excessive Thirst  
 \_\_\_ Diarrhea  
 \_\_\_ Liver Problems  
 \_\_\_ Abdominal Cramps  
 \_\_\_ Black/Bloody Stools

\_\_\_ Frequent Nausea  
 \_\_\_ Constipation  
 \_\_\_ Gall Bladder Problems  
 \_\_\_ Gas/Bloating after Meals  
 \_\_\_ Colitis

Symptom	Date Last Experienced	Treatment Received
_____	_____	_____
_____	_____	_____
_____	_____	_____



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Patient Name \_\_\_\_\_ Date \_\_\_\_\_

**Please check any of the following illnesses you have ever had:**

- |  |   |   |                                       |
|--|---|---|---------------------------------------|
| <input type="checkbox"/> Cancer        | <input type="checkbox"/> Diabetes         | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Pneumonia    |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Rheumatic Fever  | <input type="checkbox"/> Small Pox        | <input type="checkbox"/> Pleurisy     |
| <input type="checkbox"/> Polio         | <input type="checkbox"/> Chicken Pox      | <input type="checkbox"/> Arthritis        | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Epilepsy      | <input type="checkbox"/> Whooping Cough   | <input type="checkbox"/> Anemia           | <input type="checkbox"/> Mumps        |
| <input type="checkbox"/> Measles       | <input type="checkbox"/> Thyroid Disorder |   |                                       |

Symptom	Date Last Experienced	Treatment Received
_____	_____	_____
_____	_____	_____
_____	_____	_____

Doctor Initials: \_\_\_\_\_

Which best describes your reason for consulting our office?

- I have a specific concern and require help with this concern.
- I want to ensure that my child's health concerns do not become an ongoing problem that will impact their future health.
- I want my child to be healthier five years from now than they are today.

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_



## **Consent for Purposes of Treatment, Payment & Healthcare Operations (3/03)**

In this document, "I" and "my" refer to the patient, and the "Chiropractor" refers to Discover Chiropractic Clinic.

I consent to the use or disclosure of my protected health information by Chiropractor for the purpose of analyzing, diagnosing, or providing treatment for me, obtaining payment for my healthcare bills or to conduct healthcare operations of Chiropractor. I understand that analysis, diagnosis, or treatment of me by Chiropractor may be conditional upon my consent as evidenced by my signature below.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or healthcare operations of the practice. Chiropractor is not required to agree to the restrictions that I may request. However, if Chiropractor agrees to a restriction that I request, the restriction is binding on Chiropractor. I have the right to revoke this consent, in writing, at any time, except to the extent that Chiropractor has taken action in reliance on this Consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another healthcare provider, my employer, or a healthcare clearinghouse. This protected health information relates to my past, present, or future physical or mental health or condition and identifies me, of there is a reasonable basis to believe the information may identify me.

I have been provided with a copy of the Notice of Privacy Practices of Chiropractor and understand that I have a right that Notice's Notice of Practices prior signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or in the performance of healthcare operations of Chiropractor. The Notice of Privacy Practices for Chiropractor is available at the front desk of Discover Chiropractic Clinic. This Notice of Privacy Practices also describes my rights and duties of the Chiropractor with respect to my protected health information.

Chiropractor reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office of Chiropractor and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Printed Name of Patient \_\_\_\_\_

Signature of Patient or Personal Representative \_\_\_\_\_

Date of Signing \_\_\_\_\_



## TERMS OF ACCEPTANCE

When a patient seeks chiropractic healthcare and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

### **Adjustment**

An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

### **Health**

A state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.

### **Vertebral Subluxation**

A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We only offer to diagnose either vertebral subluxations or neuro-musculoskeletal conditions. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis, or treatment for those findings, we will recommend you seek the services of another healthcare provider.

We do not offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations. However, we may use other procedures to help your body hold the adjustments.

I, \_\_\_\_\_ have read and fully understand the above statements. *(Print Name)*

### **Consent to evaluate and adjust a minor child**

I, \_\_\_\_\_ being the parent of legal guardian of \_\_\_\_\_ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care. All questions regarding the doctor's objectives pertaining to my/ my child's care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis.

Patient/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_



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## Authorization to Release Medical Information

I authorize the release of medical information necessary to process my insurance claim(s) and also certify that all insurance information given to this clinic is correct and complete.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

## Agreement for Payment of Services

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that if any amount is authorized to be paid directly to this office, it will be credited to my account. **HOWEVER, I CLEARLY UNDERSTAND AND AGREE THAT ALL SERVICES RENDERED TO ME ARE CHARGED DIRECTLY TO ME AND THAT I AM PERSONALLY RESPONSIBLE FOR THE PAYMENT OF MY ACCOUNT.** It is the policy of this clinic to collect for services as they are rendered, unless other financial arrangements are made.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_



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## E-Practice Form

In our never-ending quest to serve our practice members better, we are constantly updating our database and requesting current information. By providing this information it will allow you to take advantage of and have access to our on-line scheduling, online class/lecture registration and receive up to the minute information about all the events occurring at Discover Chiropractic (including schedule changes, current events, and newsletters). This data will never be released to anyone! Our efforts are to provide you with unparalleled service. We look forward to continuing our tradition of exceeding all your expectations.

Name: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_