LEON
CHIROPRACTIC, P.C.

PEDIATRIC INTAKE FORM (Birth to 12 years)

Patient Information:

Date: ________________

Child's Name: ____ DOB: ____________________

Parent / Guardian's Name: ____

Home Phone Nbr: ____________________________ Cell Phone Nbr: ______________________

Address: ____

E-Mail Address: ____

Has your child been checked by a Doctor of Chiropractic? Yes ____ No ____

Who is your medical pediatrician? ________________________________

Prenatal History:

Is your child adopted? Yes ____ No ____

Did you have any complications and when? ____

Did you smoke? Yes ____ No ____

Did you consume alcohol? Yes ____ No ____

Did you take medication? Yes ____ No ____

If yes, reason for medication? ____

Birth History:

Did you have ultrasound during this pregnancy? Yes ____ No ____

What was the frequency? ____

Place of Birth: Home Birthing Center Hospital

Provider: Midwife OB-Gyn Other

Type of Birth: Vaginal C-Section

Were pain medications used? Yes ____ No ____

Was labor induced? Yes ____ No ____

If yes, why? ____

What position did you deliver in? Squatting On back Other

Birth Trauma? Doctor assisted Twisting/Pulling Vacuum Forceps

APGAR score birth ____/10 5 minutes ____/10 Unsure

Did your child have a misshaped skull / head? Yes ____ No ____

Were there purple markings on their face? Yes ____ No ____

Did you breast feed your child? Yes ____ No ____

Does your child prefer one breast over the other? Yes ____ No ____

If yes, which side? Right ____ Left ____

Does your child have any food allergies? Yes ____ No ____

If yes, please list: ____

Has your child been immunized? Yes ____ No ____

Reason for vaccination? Informed decision Recommended Didn't know I had a choice

Did your child have any negative reaction to the vaccinations? Yes ____ No ____

Were they reported? Yes ____ No ____

Has your child ever had any surgeries? Yes ____ No ____

If yes, please elaborate: ____

Has your child been on antibiotics? Yes ____ No ____

If yes, how often and what for? ____

Is your child currently taking any medications? Yes ____ No ____

Is your child currently taking any vitamins? Yes ____ No ____

Baby / Toddler (0-4):

Have any of the following occurred?

Falling from a changing table
Frequent crying spells
Fall out of crib
Fall off playground equipment
Play in a Johnny Jumper
Frequent ear infections
Tonsillitis

Tumble down stairs
Involvement in MVA
Frequent fevers
Reaction to vaccines
Frequent diarrhea
Constipation
Sleeping problems

Repeated colds
Colic
(+ or -) weight gain

Child (5-12):

Have any of the following occurred?

Fall from a tree
Stomach pains
Hyperactivity / Autism
Leg / Knee pains
Fall off a bicycle

Scoliosis
Learning difficulties
Sports accident
Bed wetting
Asthma

Car accident
Fall on playground
Allergies

Which of the above bothers your child the most? ______________________________

When did it begin? ______________________________

Is it getting worse? Yes ____ No ____

Is the pain: Constant Intermit Cyclic

Affect on activity? Not at all Somewhat Always

Does your child participate in any of the following?

Soccer
Hockey
Wresting
Swimming
Football
Lacrosse

Baseball / softball
Rugby
Gymnastics
Basketball
Volleyball
Karate

Dance
Tennis
Other ______________

How would you rate your child's diet? Well balanced Average High Sugar/Processed foods

Does your child consume artificial sweeteners? Yes ____ No ____

Flouridated water? Yes ____ No ____

Number of hours your child sleeps? ________ hours per day

Sleep Quality? Good Fair Poor

Is there a specific health challenge you would like the doctor to address?

____

Authorization to treat a Minor

I, ______________________________ the undersigning parent/guardian having equal custody/guardianship of ______________________________, a minor, do hereby authorize, request and direct Dr. Leon and whomever he may designate as assistant to perform in judgment any examination and chiropractic diagnosis or treatment which is deemed necessary.

Patient: ______________________________ Signature: ______________________________

LEON CHIROPRACTIC
213 Hallock Road, Suite 4B
Stony Brook, NY 11790
631-689-1000

Notice of Privacy for Patient's Protected Health Information

This notice describes how health care information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This office abides by the terms described in this policy.

This office uses and discloses your protected health care information for the following reasons:

- To share with other treating health care providers regarding your health care.
- To submit to insurance companies or Worker's Compensation to verify that treatment has been rendered.
- To determine patient's benefits in a health care plan.
- To release information required by State or Federal Public Health Law.
- To assist in overcoming a language barrier when caring for a patient.
- To business associates, providing written assurances for your privacy have been attained.
- Emergency situations.
- Abuse, neglect, or domestic violence.
- Appointment reminders to household members and/or answering machines.
- Sign-in logs may be disclosed to verify office visits.
- To send out birthday cards and newsletters.

Any other uses or disclosures will only be made with your specific written prior authorizations.

You have the right to:

- Revoke authorization, in writing, at any time by specifying what you want restricted and to whom.
- Inspect, copy and amend your protected health information and amend it as allowed by law.
- Obtain an accounting of disclosures of your protected health information.
- Render a complaint to our privacy officer.

This office reserves the right to change the terms of this notice and make new notice provisions for all protected health information that it maintains. Patients may also get an updated copy upon request at any time by asking the staff.

I acknowledge that I have received and review this notice with full understanding.

______________________	____________________________________	________
Name of Patient	Signature of Patient/Legal Representative	Date