



PEDIATRIC INTAKE

Date / /

Patient Name: _____ Age : _____ D.O.B. / /

Address: _____

City: _____ State: Zip: _____

Name of Parent(s) or Guardian : _____

Home Phone:() _____ Mother's Work Phone: () _____

Father's Work Phone: () _____ Sex: Male or Female (circle one)

No. of Siblings: _____ Handedness: Right or Left (circle one)

Pediatrician's name & address: _____

Date of last visit: / / Reason: _____

Has this patient ever been seen by a Chiropractor? _____ Doctor's Name: _____

Date of last D.C. visit: / / Reason: _____

CHIEF COMPLAINT

Purpose of this appointment: _____

Please list all of the therapies undergone for this complaint (including medications):

Date of onset: / / Onset was: Sudden or Gradual (circle one)

Duration of pain (problem or episode): _____ Minutes Hours Days Months Years (circle one)

Pattern of pain (problem): Constant Intermittent Occasional (circle one)

What makes it worse? _____

What makes it better? _____

PRENATAL HISTORY

Duration of Gestation: _____ weeks Pregnancy Normal? Yes or No (circle one)

List any significant complications during pregnancy: _____

List any medications taken during the pregnancy: _____

Type of birth: Normal Vaginal Forceps / Vacuum Breech C-Section (circle one)

List any complications during delivery: _____

NUTRITIONAL HISTORY

Infant feeding: Breast milk or Formula (circle one)

Began solid foods at age: _____ months Cow's milk began at age: _____ years

Does your child have any food allergies? _____

Does your child eat a healthy variety of foods, including whole grains, fruits and vegetables? _____

Please describe your child's eating habits (e.g., good appetite, picky eater, etc.): _____

DEVELOPMENTAL HISTORY

Does your child have any developmental delays? Yes or No (circle one)

If "No", explain: _____

Socially, does your child seem normal for his/her age? Yes or No (circle one)

If "No", explain: _____

What time does your child usually go to bed? _____ Wake in the morning?: _____

Does your child nap during the day?: Yes or No

CHILDHOOD DISEASES / IMMUNIZATION HISTORY

Has your child ever experienced any of the following illnesses (Please Circle)?

Rubella	Mumps	Measles	Chickenpox
Whooping Cough	Scarlet Fever	Polio	Rheumatic fever
Diaper rash	Cradle cap	Diarrhea	Constipation
High Fevers	Bedwetting	Strep throat	Frequent Colds
Stomachaches	Headaches	Gastroesophageal Reflux	Heat or Cold Intolerance

Ear infections: How many and how often?: _____

Has your child received any of the following vaccinations ?

DPT _____ MMR _____ Hib _____ Polio _____
TB _____ Flu _____ Smallpox _____ Pneumovax _____
Chickenpox _____ Other: _____

Did your child have any adverse reactions or chronic illness following a vaccination?

Has your child ever suffered from:

____ neck pain ____ low back pain ____ muscle jerking ____ arthritis
____ headaches ____ leg problems ____ convulsions ____ broken bones
____ dizziness ____ orthopedic problems ____ arm problems ____ growing pains
____ walking problems

Problems not listed above: _____

Does your child get regular screening tests done by another doctor? Yes or No (circle one)

Has your child had any serious conditions, illnesses or injuries, or any hospitalizations or surgeries?

Please list along with approximate dates.

Does your child have any known allergies (medicines, environmental, etc.)?

Please list all medications your child is currently taking: _____

Please list all Vitamins or Nutritional Supplements your child is currently taking: _____

AUTHORIZATION FOR CARE OF A MINOR

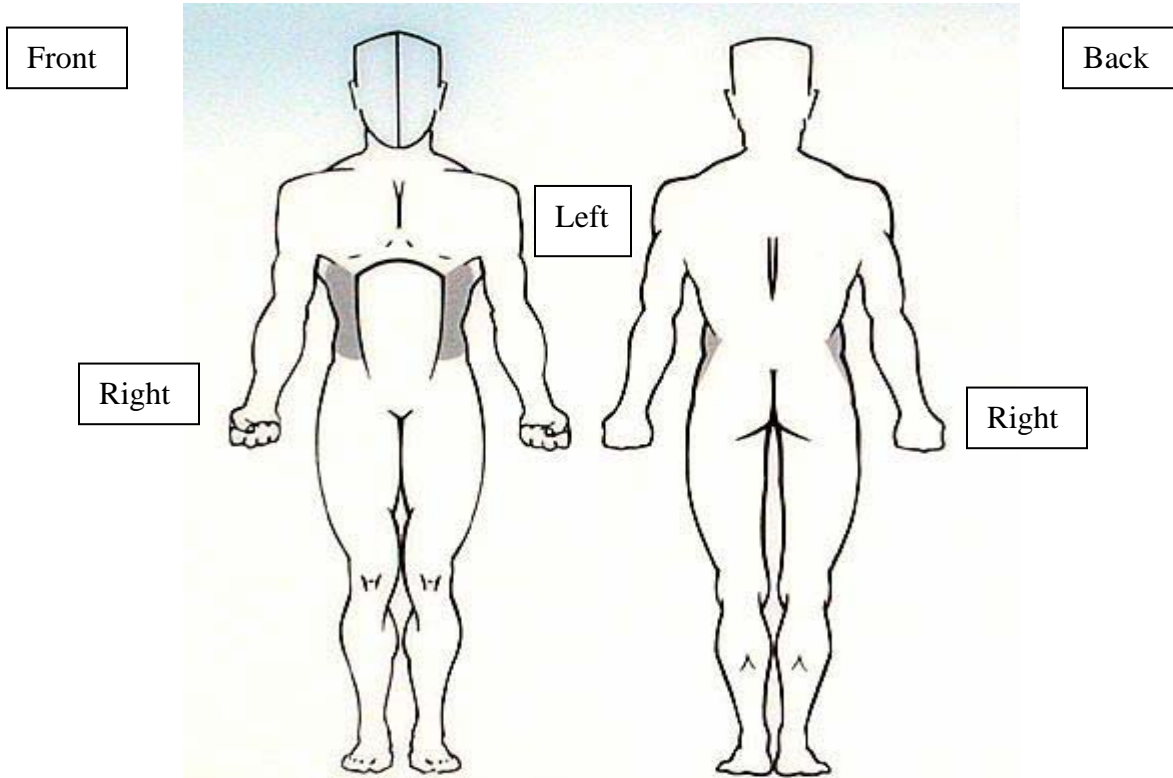
I hereby authorize Koster Family Chiropractic, LLC, Dr. Michael J. Koster and whomever they may designate to administer care as they deem necessary to my son / daughter.

Signed: _____ Date: ____/____/_____

Name: _____

Date: _____

Mark the areas on your body where you feel the following sensations:
Pain **XXX** Numbness **OOO** Pins and Needles **---**
Burning **BBB** Stabbing **///** Other **+++**



Visual Analog Scale

Indicate the severity of your pain by marking an "X" at the appropriate point on pain line
0 is "NO PAIN" and 10 is the "WORST PAIN" you have ever felt.

How bad is your neck pain now?



How bad is your back pain now?



How bad is your arm pain now?



How bad is your leg pain now?





From the office of Dr. Michael J. Koster...

THIS NOTICE DESCRIBES HOW CHIROPRACTIC AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

In the course of your care as a patient at Koster Family Chiropractic we may use or disclose personal and health related information about you in the following ways:

- Your protected health information, including your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment, or treatment.
- Your health care records as well as your billing records may be disclosed to another party, such as an insurance carrier, an HMO, a PPO, or your employer, if they are or may be responsible for the payment of services provided to you.
- Your name, address, phone number, and your health care records may be used to contact you regarding appointment reminders, information about alternatives to your present care, or other health related information that may be of interest to you.

You have a right to request restrictions on our use of your protected health information for treatment, payment and operations purposes. Such requests are not automatic and require the agreement of this office.

Your name, address, telephone number, e-mail address and health records may be used to contact you regarding appointment reminders, information about alternatives to your present care, or other health related information that may be of interest to you.

If you are not home to receive an appointment reminder or other related information, a message may be left on your answering machine or with a person in your household. You have a right to confidential communications and to request restrictions relative to such contacts. You also have the right to be contacted by alternative means or at alternative locations.

We are permitted and may be required to use or disclose your health information without your authorization in these following circumstances:

- If we provide health care services to you in an emergency.
- If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.
- If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.
- If we are ordered by the courts or another appropriate agency.

You have the right to receive an accounting of any such disclosures made by this office. Any use or disclosure of your protected health information, other than as outlined above, will only be made upon your written authorization. If you provide an authorization for release of information you have the right to revoke that authorization at a later date.

Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

We normally provide information about your health to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your health care or about the status of your account. If you would like to receive this information at an address other than your home or if you would like the information in a specific form please advise us in writing as to your preferences.

You have the right to inspect and/or copy your health information for as long as the information remains in our files. In addition you have the right to request an amendment to your health information. Requests to inspect, copy or amend your health related information should be provided to us in writing.

We are required by state and federal law to maintain the privacy of your patient file and the health protected information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information. We are further required by law to abide by the terms of this notice while it is in effect.

We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice we will notify you in writing as soon as possible following the changes. Any change in our privacy notice will apply for all of your health information in our files.

If you should have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities, or if you would like further information about our privacy policies and practices, you should direct your concerns in writing to: ***Koster Family Chiropractic, LLC, Attention HIPAA Concerns, 124 Simsbury Rd, Box 12E, Avon, CT 06001.***

You also have the right to lodge a complaint with the Secretary of the Department of Health and Human Services. If you choose to lodge a complaint with this office or with the Secretary, your care will continue and you will not be disadvantaged by this office or our staff in any manner whatsoever.

This notice is effective as of _____. This notice, and any alterations or amendments made hereto will expire seven years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice.

Name (please print)

Signature

Date

If you are a minor, or if you are being represented by another party:

Personal Representative Name

Representative Signature

Date

Description of the authority to act on behalf of the patient



Patient Authorization regarding chiropractic care and physiotherapy, being provided in an “open treatment” environment...

It is the practice of this office to provide health care in an “open treatment” environment. “Open treatment” involves several patients being in the same room at the same time. Patients are within sight of one another and some ongoing routine details of care are discussed within earshot of other patients and staff. This environment is used for ongoing care and is NOT the environment used for consultation, history taking, performing examinations or presenting reports of findings. These procedures are completed in a private, confidential setting.

We are requesting this authorization of you due to various interpretations under federal law with respect to what is known as an “incidental disclosure” of health information. It is our view that the kinds of matters related in an “open treatment” environment are incidental matters, in the event you or someone else would not agree with us, we are providing this disclosure.

The use of this format is intended to make your experience with our office more efficient and productive, as well as to enhance your access to quality health care and health information. If you choose not to be treated in an open treatment environment, other arrangements will be made for you. Your decision will have no adverse effect on your care from Dr. Koster or on your relationship with our staff.

Your signature indicates your authorization of this activity.

Name (printed)

Signature

Date

This authorization may be revoked by you at any time. Revocation may be accomplished by advising us in writing of your desire to withdraw your authorization. Please allow a reasonable processing time for the change in our procedures to be completed.