Wellspring
HEALTH & SPORTS PERFORMANCE

New Patient Children's Intake Form

Name: _____ Birthdate:____/____/_____ Age: _____ Sex: M__ F__

Parent/Guardian Name: _____ Relation:_____

Phone:(H)_____ (Cell)_____ Email:_____

Address: _____ Apt:#_____

City: _____ State:_____ Zip: _____

Siblings (please include ages): _____

Employer: _____ Position: _____

Spouse: _____ Spouse DOB: ___/___/_____ Spouse Employer: _____

Primary Care/Pediatric Physician:_____ Did s/he refer you? Yes___ No___

How did you hear about our office? _____

Insurance Company Name: _____ Insured DOB: ___/___/____

Insured's Employer: _____ Insured's SS#:_____

Assignment of Insurance Benefits:
I assign the payment of benefits due to me under my insurance policy with my carrier, and my direct insurance carrier to pay for all services rendered directly to Wellspring Health and Sports Performance.

Release of Medical Information to Insurance Carrier:
I give permission to Wellspring Health and Sports Performance to release all medical information files in relation to my history and treatments to my insurance carrier in order to facilitate processing of insurance claims.

Informed Consent Agreement:
If I do not understand the necessity for, or the risk of, any therapy of manipulative procedure used in my care, I may request an explanation before performed so that I may give informed consent or objection.

Consent to treat a Minor:
I hereby authorize Dr. Kampfe and his assistants to administer the medically necessary chiropractic care and therapy, as they deem necessary, and without my presence when necessary, to the above names patient, my _____ (relationship to minor).
I sign here for consent to treat my minor: _____

****All the above and following confidential health information has been read and is completed as true by the below signed individual who is responsible for the answering of these statements and the balance of payments on these accounts:**

Signature: _____ Date: _____

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1. What is your major concern?_____

2. What do you believe caused this problem?_____

3. When did the symptoms start? _____

4. How frequent is the condition? Constant:____ Intermittent:____ Night Only:____ Day Only:____

5. How long does it last? All Day:____ Few Hours:____ Minutes:____ Seconds:____

6. What makes the problem worse?

_____

7. Is there anything you can do to relieve the problem? Yes____ No____

If yes, please describe: _____

8. Has any doctor recently treated your child for this condition? Yes___ No___

Doctor:_____ When:_____

9. Any (check all that apply): X-Rays:___ MRI:___ Medication:___ Injections:___

Other:_____

10. Results: None:___ Fair:___ Good:___ Worse:___ Other:_____

11. Are there any other conditions or symptoms you have noticed that may be related to your major concern? (Circle One) Yes No If yes, please describe:

_____

12. List medications given within the last 7 days: _____

13. Last blood work date: _____ Physician Ordering: _____

14. List ALL allergies: _____

_____

15. Have they had any chiropractic or muscle therapy for this condition in the past? Yes___ No___

16. Did you find the prior treatments and experiences helpful? Yes___ No___

Doctor: _____ Treated from:_____ to:_____

What conditions were treated?_____

17. Have they had Acupuncture treatments, Neuromuscular therapy, Herbal or Vitamin therapies ever?

If yes, please explain: _____

18. Any perceived changes in their senses lately? Circle the sense(s) in which you have noticed a change.

Smell Taste Touch Hearing Vision Balance Equilibrium

Patient's Name: _____ Date:_____

Parent/Guardian Initials:_____

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The following section is for Children from Infancy to Age 3:

1. Your child was born by: (please circle one)

   Vaginal Delivery

   Scheduled C-Section

   Emergency C-Section

2. Was any pain medication (Epidurals, etc.) used during the labor: (Please circle one) Yes No

   If yes, please list: _____

3. Was there any medical assistance needed for delivery? (Forceps, Vacuum, etc) Yes No

   If yes, please list: _____

4. How long was labor: _____

5. Was labor induced or any other methods used to help the process: _____

6. Has your child received their shots: (please circle one) Yes No

   If yes, please list which ones they've received: _____

   _____

7. Did your child experience any reactions to their shots: (please circle one) Yes No

   If yes, please describe symptoms and which shots caused the reaction: _____

   _____

8. Feeding: (please circle one) Breastfed Formula Mixture of both

9. Do you have any concerns regarding motor function? (please circle one) Yes No

   If yes, please explain: _____

10. Have you noticed any preference or favoring of the Left side or the Right side?

    (please circle one) Yes No

    If yes please explain when and during what activities:_____

    _____

11. Please list any other concerns not listed above: _____

_____

_____

Patient's Name: _____ Date:_____

Parent/Guardian Initials:_____