www.DRFunctionalNeurology.com
Chiropractic & Functional Neurology
972.322.2280 * 972.695.6306 Fax

PEDIATRIC BASIC INTAKE FORM

PREPARING FOR THE FIRST VISIT

1. Both parents (or legal guardians) are recommended to be at the first visit with the child.
2. Total time for the first visit will be about an hour. Make sure the child is well fed, rested and hydrated.
3. Please bring the completed ***BASIC PEDIATRIC INTAKE FORM*** with you. Dr. Rosenthal will review the records before he sees you and your child.
4. Please bring any medical records, DVD's, films or copies of therapy notes with you. Dr. Rosenthal needs to review these to get a complete picture of your child's health.
5. If needed please bring diapers, binky's, bottles, wet wipes, books or snacks so the child will be comfortable.
6. Please explain to the child why they are coming to the office. Re-assure them there will be no needles or shots during their visit.
7. The first visit should last about an hour. Additional time may be necessary depending on the complexity.

FINANCIAL POLICY

We are committed to the successful completion of your treatment program. Please understand the payment of your bill is considered a part of your treatment. The following is a statement of our financial policy, which we require you to read and sign prior to any treatment.

Full payment is expected at the time of service. We accept cash, checks, Visa, MasterCard, and American Express. We do not accept assignment of insurance, but do provide you with the necessary paperwork so that you may be re-imbursed by your insurance company.

We realize that due to the rising cost of healthcare, it makes it very difficult for the average person to receive often needed care. It is therefore our policy that no person will be turned away due to financial burdens. We have flexible payment plans that are affordable.

REGARDING INSURANCE

Our policy is to recommend what is best for each patient. What an insurance company may or may not re-imburse is between the patient and the patient's insurance company. This office will not and cannot set its recommendations by what an insurance company's policy may be. This office will not enter into dispute with an insurance company regarding reimbursement. This is the patient's responsibility.

We do not know if your policy covers chiropractic care or not, and make no representations that yours does. Some insurance policies now cover chiropractic care and they range from a large deductible and a percentage of the bill to a no deductible and 100% of the bill.

SCHEDULING OF APPOINTMENTS

One of the most precious gifts is our time. To heal in a timely fashion it is important that you keep your appointments as scheduled by your doctor. Schedule ahead as this will assure you of getting the appointment time you want, and the care you need and deserve. **Unless canceled at least 24 hours in advance**, our policy is to **charge for missed appointments** at the rate of a normal office visit. Please help us serve you better by keeping your scheduled appointments.

The goal of chiropractic care in this office is to improve your child's ability to achieve his or her optimal developmental potential. We are here to help you. Remember, neither one of us has anything to gain if you delay treatments for financial reasons. We will do everything possible to make your care affordable so that you can follow through on your treatment schedule.

I have read the financial policy. I understand and will abide to the terms of the agreement here within.

Name of **Patient**: _____ (Please print)

Name of Parent or Guardian: _____

Signature of Parent or Guardian: _____

Date: _____

PEDIATRIC CASE HISTORY

Child's name:_____Birth date:_____ Age:_____Today's date:_____

Home Address:_____Home phone#:_____ Number of siblings:_____

City:_____State:_____Zipcode:_____

Mother's name: _____ Mother's *Birth date*: _____*Cell#*: _____*Work#*: _____

Mother's email: _____ *Mother's Occupation*:_____ *Mother's S.S.#*:_____

Father's name: _____Father's Birth date: _____Cell#: _____Work#: _____

Home Address:_____

City:_____State:_____Zipcode:_____

Father's email: _____ Father's Occupation:_____Father's S.S.#: _____

Who may we thankk for referring you:_____

Past Chiropractic Care: ☐Yes ☐No Who/When:_____

Past Cranial Care: ☐Yes ☐No Who/When:_____

Why are you consulting us today:

1._____

2._____

3._____

4._____

5._____

What are the goals you have for your child/what would you like to see improve?

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____

Is there any history of auto-immune disease in the family (celiac disease, rheumatoid arthritis, lupus, etc.)?_____

How many ultrasounds did the Mother have during the pregnancy? _____

Did the mother have any dental amalgams (Mercury) prior to the pregnancy? ☐Yes ☐No If yes please explain:_____

_____

Did the mother have any traumas during the 3rd trimester? ☐Yes ☐No If yes please explain:_____

_____

Birth weight: _____ Birth length:_____Current weight:_____ Current length/height:_____

Third Trimester Presentation (please circle): Normal vertex BREECH Transverse Face/Brow(Hyperextension) Unknown

Type of birth (please circle): Normal vaginal Forceps Cesarean Suction/Vacuum/Suction Cap Induced Labor

Location of birth (please circle): Home Birthing center Hospital Other _____

Complications during pregnancy: ☐Yes ☐No If yes please explain: _____

_____

Problems during labor/delivery: _____

_____

Was there oxytocin/ptocin used during the pregnancy? ☐Yes ☐No Was an epidural administered? ☐Yes ☐No

Was an episiotomy performed during the pregnancy? ☐Yes ☐No Was there vaginal tearing during the pregnancy ☐Yes ☐No

Pharmaceuticals taken during pregnancy, labor/delivery?: _____

_____

APGAR scores at birth: _____ Later APGAR scrores: _____

Was there the presence at birth of: Jaundice (yellow) _____ Cyanosis (blue) _____

Congenital defects/anomalies: ☐Yes ☐No If yes, please explain: _____

Was there any swelling of the child's head after birth: ☐Yes ☐No If yes, please explain: _____

Infant feeding: Breast _____ Bottle_____ If bottle, which formula(s):_____

Number of hours sleeping per night: _____ Quality of sleep (please circle): Excellent Good Fair Poor

Obstetrician/Midwife: _____

Pediatrician/Family MD: _____

Date of last visit with pediatrician/MD:_____ Purpose: _____

History of immunization (Please see last page for detilas or attach further information if available):

_____

_____

Antibiotic use last 2 months: _____ Antibiotic use since birth: _____

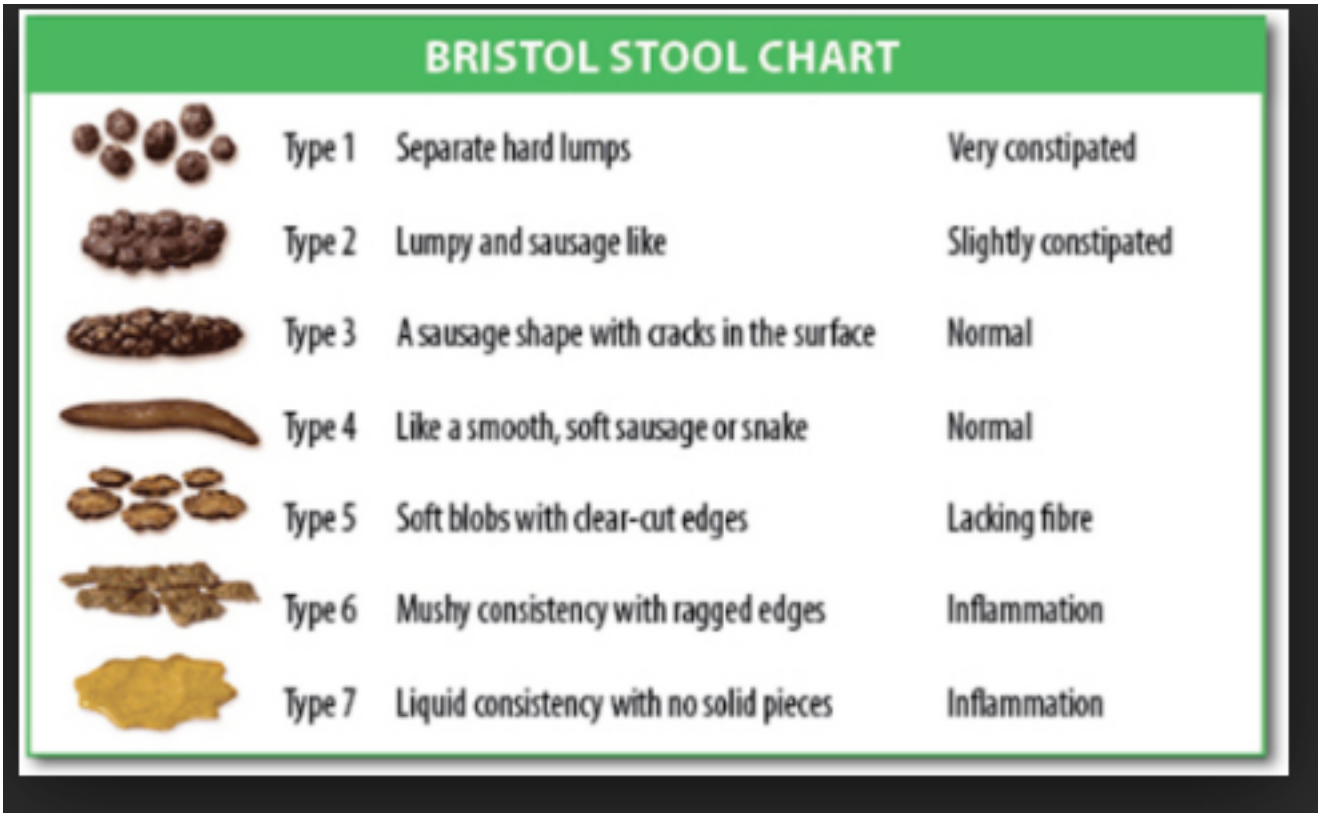
Has your child ever been treated in the ER?: ☐Yes ☐No Purpose: _____

_____

What is the blood type (please mark): ☐ A+ ☐A- ☐ B+ ☐ B- ☐ AB+ ☐ AB- ☐ O+ ☐ O-

How many bowel movements does the child have per day (please mark): ☐ 1 ☐ 2 ☐ 3 ☐ every other day ☐ once a week ☐ other_____

Please circle the type of stool your child typically produces:



Are there pets at home? ☐Yes ☐No If yes, what type?_____

Are there smokers in the home? ☐Yes ☐No If yes, who? _____

Does your child put pressure on his/her stomach ☐Yes ☐No If yes, what _____

At what age did your child:

Respond to sound: _____
Follow an object with his/her eyes: _____
Roll over: _____
Hold head up: _____
Potty trained: _____

Sit up alone: _____ (7mos)
Crawl: _____ (by 12 mos).
Stand: _____
Walk alone: _____(18 mos)
Dry at night: _____ (4-5 y.o)
Lose language: _____

At what age did your child suffer any of the following childhood diseases:

☐Chickenpox _____
☐ Measles _____
☐ Mumps _____
☐ Rubella _____

☐ Rotavirus _____
☐ Whooping cough _____
☐ Influenza _____
☐ Hepatitis _____

☐ RSV (Synctial) infection _____
☐ Tuberculosis _____
☐ Influenza _____
☐ Other _____

Has your child ever suffered from:

- ☐ Arm problems
- ☐ Acid reflux
- ☐ ADD/ADHD
- ☐ Anemia
- ☐ Autism spectrum disorder
- ☐ Autoimmune disease
- ☐ Back aches
- ☐ Bed wetting/enuresis
- ☐ Behavioral problems
- ☐ Brain injury
- ☐ Bronchitis
- ☐ Cerebral palsy
- ☐ Chronic ear aches
- ☐ Cold/flu
- ☐ Colic
- ☐ Bruxism(teeth grinding)
- ☐ TMJ/TMJD
- ☐ Spina bifida
- ☐ Constipation
- ☐ Diabetes
- ☐ Diarrhea
- ☐ Digestive problems
- ☐ Dizziness
- ☐ Down's syndrome (Trisomy 21)
- ☐ Dyslexia
- ☐ Growing pains
- ☐ Headaches
- ☐ Heart problems
- ☐ High blood pressure
- ☐ Joint problems
- ☐ Leg problems
- ☐ MRSA
- ☐ OCD(Obsessive Complusive Disorder)
- ☐ Multiple sclerosis (MS)
- ☐ Hyperactivity
- ☐ Otitis media
- ☐ Muscular dystrophy (MD)
- ☐ Muscle pains
- ☐ Neck problems
- ☐ PDD/PDD-NOS
- ☐ Poor appetite
- ☐ Poor posture
- ☐ Scoliosis
- ☐ Seizures/convulsions
- ☐ Sinus trouble
- ☐ Skin problems
- ☐ Stomach aches
- ☐ Vision problems
- ☐ Erb's palsy
- ☐ Klumpke's palsy
- ☐ Brachial plexus injury
- ☐ Allergies_____
- ☐ Other _____
- ☐ Allergies_____

Has your child ever had any of the following traumas:

- ☐Fall down stairs
- ☐Fall from bed/couch
- ☐Fall from bicycle
- ☐Fall from changing table
- ☐Fall from crib
- ☐Fall from high chair
- ☐Fall from monkey bars
- ☐Fall from roller blades
- ☐Fall from tree
- ☐Fall in baby walker
- ☐Fall off skateboard
- ☐Fall off slide
- ☐Fall off swing
- ☐Other _____
- ☐Other _____
- ☐Other _____

Has your child ever been injured playing sports? ☐Yes ☐No If yes, please explain: _____

_____

Does your child wear: ☐ Corrective lenses ☐ Dentures ☐ Hearing aid ☐ Medical device, prosthetic, etc._____

_____

What color is the child's hair: _____What is the child's eye color:_____

Has your child ever been injured in a **motor vehicle accident** ? ☐Yes ☐No If yes, please explain: _____

_____

Has your child ever had any surgeries? ☐Yes ☐No If yes, please explain: _____

_____

Has your child been taking any medications? ☐Yes ☐No If yes, please explain: _____

_____

Does your child have any allergies to the environment or medications? ☐Yes ☐No If yes, please explain:
_____

_____

Has your child had any behavioural or motor developmental delays? ☐Yes ☐No If yes, please explain: _____

_____

What is the child's blood type (please mark): ☐ A+ ☐A- ☐ B+ ☐ B- ☐ AB+ ☐ AB- ☐ O+ ☐ O-

How many bowel movements per day (please mark): ☐ 1 ☐ 2 ☐ 3 ☐ every other day ☐ once a week ☐ other_____

Does your child take any nutrional supplements? ☐Yes ☐No If yes, please explain: _____
_____
_____
_____
_____
_____
_____

What are the five (5) foods your child cannot live WITHOUT:

1. _____
2. _____
3. _____
4. _____
5. _____

Does your child refuse to eat any foods?: _____
_____
_____
_____

What other concurrent therapies are you pursuing for your child at this time:

Speech therapy	Occupational therapy	Physical therapy
ABA (Applied Behaviour Analysis)	Hippotherapy	Sensory integration
Chelation therapy (IV, Oral, Rectal)	Therapeutic optometry	Nutritional therapy
Anti-fungals (Nystatin, etc.)	LDA (Low Dose Antigen)	Auditory training
Neurofeedback	Hyperbaric chamber	Far/near infrared sauna
The Listening Program	Pharmacological medications	

Is there anything else that you would like us to evaluate?: _____

_____

Immunization	Please give approx. date if you don't have an exact one.	Did you have any of the following reactions: "Bowel" means any bowel symptom such as diarrhea, "Swelling" means swelling at the site of injection.

Diphtheria-Pertussis-Tetnus	**Date**	**Bowel**	**Swelling**	**Crying**	**Seizure**	**Irritable**	**Fever**	**No Reaction**
DTP 1		☐	☐	☐	☐	☐	☐	☐
DTP 2		☐	☐	☐	☐	☐	☐	☐
DTP 3		☐	☐	☐	☐	☐	☐	☐
DTP 4		☐	☐	☐	☐	☐	☐	☐
DTP 5		☐	☐	☐	☐	☐	☐	☐
Adult Diphtheria-Tetanus		☐	☐	☐	☐	☐	☐	☐
Pediatric Diphtheria-Tetanus		☐	☐	☐	☐	☐	☐	☐

H Influenza Type B	**Date**	**Bowel**	**Swelling**	**Crying**	**Seizure**	**Irritable**	**Fever**	**No Reaction**
Hib 1		☐	☐	☐	☐	☐	☐	☐
Hib 2		☐	☐	☐	☐	☐	☐	☐
Hib 3		☐	☐	☐	☐	☐	☐	☐
Hib 4		☐	☐	☐	☐	☐	☐	☐

Oral Polio Vaccine	**Date**	**Bowel**	**Swelling**	**Crying**	**Seizure**	**Irritable**	**Fever**	**No Reaction**
OPV 1		☐	☐	☐	☐	☐	☐	☐
OPV 2		☐	☐	☐	☐	☐	☐	☐
OPV 3		☐	☐	☐	☐	☐	☐	☐
OPV 4		☐	☐	☐	☐	☐	☐	☐
OPV 5		☐	☐	☐	☐	☐	☐	☐

Polio Vaccine Injection	**Date**	**Bowel**	**Swelling**	**Crying**	**Seizure**	**Irritable**	**Fever**	**No Reaction**
Polio Vaccine Injection 1		☐	☐	☐	☐	☐	☐	☐
Polio Vaccine Injection 2		☐	☐	☐	☐	☐	☐	☐
Polio Vaccine Injection 3		☐	☐	☐	☐	☐	☐	☐
Polio Vaccine Injection 4		☐	☐	☐	☐	☐	☐	☐
Polio Vaccine Injection 5		☐	☐	☐	☐	☐	☐	☐

Measles-Mumps-Rubella	**Date**	**Bowel**	**Swelling**	**Crying**	**Seizure**	**Irritable**	**Fever**	**No Reaction**
MMR 1		☐	☐	☐	☐	☐	☐	☐
MMR 2		☐	☐	☐	☐	☐	☐	☐

Hepatitis-B Vaccine	**Date**	**Bowel**	**Swelling**	**Crying**	**Seizure**	**Irritable**	**Fever**	**No Reaction**
HBV 1		☐	☐	☐	☐	☐	☐	☐
HBV 2		☐	☐	☐	☐	☐	☐	☐
HBV 3		☐	☐	☐	☐	☐	☐	☐
HBV 4		☐	☐	☐	☐	☐	☐	☐

Miscellaneous	**Date**	**Bowel**	**Swelling**	**Crying**	**Seizure**	**Irritable**	**Fever**	**No Reaction**
Varivax (Chicken Pox)		☐	☐	☐	☐	☐	☐	☐
Tine Test		☐	☐	☐	☐	☐	☐	☐
Other:		☐	☐	☐	☐	☐	☐	☐

Review of Systems©

Please circle any of these that apply

Constitutional:	Growth problems	Fatigue	Fevers
	Weight loss	Weight gain	Poor appetite
	Chills	Obesity	Muscle wasting
Eyes	Blurred vision	Double vision	Drainage
	Glaucoma	Diabetes	Near sighted
	Far sighted	Use glasses	Color blindness
	Floaters	Cataracts	Use contacts
Nose/Throat	Loss of smell	Ringing in ears	Current/chronic Infections
	Dryness eyes/nose	Swelling nose/throat	Dizziness
	Drooling	Adenoids	Recent/chronic yeast infection
	Lip tie at birth		
	Ulcers		Tongue tie at birth
Cardiovascular	Blue lips	Blue fingers	Swelling feet
	Hypertension	Tobacco use	Regurgitation
	Swelling hands	Cold feet	Cold hands
	Red hands	White hands	Murmurs
	Chest pain with rest	Chest pain with exertion	Congestive heart failure
Respiratory	Persistent cough	Shortness of breath at rest	Shortness of breath with exertion
	Asthma	Bronchitis	
Gastro-intestinal	Belly pain	Constipation	Diarrhea
	Reflux	Vomitting	Nausea
	Gas/Bloating	Belching	Loss of control
Gastro-urinary	Difficulty urinating	Bed-wetting	Blood
	Late night urination	Loss of control	Urinary incontinence
	Bowel incontinence		
Musculoskeletal	Pain	Problems walking	Weakness
	Arthritis	Joint pain	Problems moving
Skin and hair	Itching	Rashes	Lesions
	Eczema	Allergies	White lines on nails
	Ingrown hair	Dryness	Excessive sweating

	Absent sweating	Nevus	
Neurological/ developmental	Seizures	Floppy tone	Cerebal palsy
	Fainting	Headaches	Epilepsy
	Multiple sclerosis	Incoordination	Stroke
	Autism	ADD	ADHD
	Parkinson's	Traumatic brain injury	Concussion
	Erb's palsy	Klumpke's palsy	Arnold chiari malformation
	Patent foramen ovale		
	Aspergers	Visual midline shift	Muscular dystrophy
Blood/Lymph	Bleeding	Bruising easily	Swelling
	Diabetes	Poor wound healing	Recent transfusion
Endocrine	Hair loss	Hormone replacement	Hyperthyroidism
	Hypothyroidism	Hashimoto's	
Allergic/Immunologic	Environmental	Seasonal	Auto-immune
	Latex	Anaesthesia problems	Drug allergies
Psychiatric	Behavioural changes	Personality changes	Sadness
	Mania	Agitation	Visual hallucinations
	Anxiety	Obsessive	Auditory hallucinations
	Bipolar	Psychosis	Self injuring
	Sadistic	Depression	OCD
	Suicial thoughts		
Sleep	Problems getting to sleep	Problems staying asleep	Sleep walking
	Well rested after sleep	Enjoy naps	
Genetic	Ehlers-Danlos Syndrome	Cystic fibrosis	
	MECP2	CDKL5	Downs Syndrome
Corrective and/or supportive devices	AFO	Shoes	Leg brace
	Spinal brace	Arm brace	Helmet
	Wheelchair	Crutches	Cane
Hand dominance	Right	Left	Don't know
Foot dominance	Right	Left	Don't know
Eye dominance	Right	Left	Don't know
Ear dominance	Right	Left	Don't know

Family Health History©

Please mark any of these that apply

Family History	Heart disease	Vascular	Cancer	Thyroid	Obesity	Diabetes	Genetics	Other
Father								
Mother								
Brother 1								
Brother 2								
Brother 3								
Sister 1								
Sister 2								
Sister 3								
Grandfather (Father's side)								
Grandmother (Father's side)								
Uncle 1 (Father's side)								
Uncle 2 (Father's side)								
Aunt 1 (Father's side)								
Aunt 2 (Father's side)								
Grandfather (Mother's side)								
Grandfather (Mother's side)								
Uncle 1 (Mother's side)								
Uncle 2 (Mother's side)								
Aunt 1 (Mother's side)								
Aunt 2 (Mother's side)								
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Do you suffer from any condition other than that for which you are now consulting us? ☐ No ☐ Yes Explain:

AUTHORIZATION FOR EVALUATION, MANAGEMENT AND SUPPORT

I clearly understand and agree that all services rendered to me will be charged directly to me and that I am personally responsible for all payments. There are inherent risks in every health care delivery system. Chiropractic health care is no exception. We want you to be informed of potential events associated with chiropractic health care before consenting to evaluation, management and support.

I also understand that if I suspend or terminate my care, any fees for professional services rendered to me will be immediately due and payable. I hereby authorize Dr. David Rosenthal to examine and manage my condition as he deems appropriate through the use of Chiropractic health care, and I give authority for these procedures to be performed. Chiropractic manipulation/adjustment is the introduction of energy with the use of the Doctor's hands or with calibrated instruments. Frequently the maneuvers are associated with a "pop" or "click" sound or sensation in the area being evaluated, managed or supported.

Dr. Rosenthal will not be held responsible for any pre-existing medically diagnosed conditions nor any medical diagnosis. I understand that management and recommendations involve the use of chiropractic care and may or may not incorporate various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound, hydrotherapy, dietary modification, exercise recommendations, brain-based rehabilitation, and nutritional supplementation.

I am fully aware and agree to the statements below with my initials:

1.	_____Initials	I am fully aware and agree that Dr. David Rosenthal is licensed in the state of Texas as a Doctor of Chiropractic (DC) and not a medical doctor (md).
2.	_____Initials	I am fully aware and agree that Dr. Rosenthal is not licensed as a primary care physician in the state of Texas and that if I do have a diagnosable medical condition will seek care from a medical physician licensed to treat my specific diagnosis, condition, or disease process. I will not hold Dr. Rosenthal liable for being a primary care physician in the state of Texas.
3.	_____Initials	I am fully aware and agree that Dr. Rosenthal may make recommendations to manage my case that may include: diet, brain-based exercises, nutritional advice, and nutritional supplementation. I understand that nutrition is not an exact science. I acknowledge that no claims or guarantees have been made to me regarding me or my child's (ward's) as a result of Dr. Rosenthal's chiropractic care.
4.	_____Initials	**POSSIBLE RISKS:** As with any health care procedure, complications are possible following chiropractic intervention. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or minor complications. The risks of stroke complications due to chiropractic treatment are so rare that no statistical literature is available to calculate possibility. The risk of cerebrovascular injury, or stroke, has been estimated between one in one million and one in twenty million manipulations/adjustments. The probability of adverse reactions due to ancillary procedures are also so rare that no statistical literature is available to calculate.
5.	_____Initials	I agree to accept full responsibility for applying the advice I receive and for any risk that may be involved in applying these chiropractic procedures and/or principles.

6.	_____Initials	I am fully aware and agree that Dr. Rosenthal does not prescribe any allopathic medical treatments or pharmaceutical medications.
7.	_____Initials	I am fully aware and agree that nutritional recommendations including vitamins, minerals, herbals and homeopathics are used for support and educational purposes only and not intended to render medical advice or serve as any treatment protocol for any pathology, disease or disorder. The nutritional protocols are used to support various body systems. The products recommended are only intended as support for natural metabolic processes that are under temporary stress or to address an additional demand for nutrients. These recommendations have not been evaluated by the Food and Drug Administration and should not be construed as claims to treat, cure or prevent disease, as they are not intended to act as drugs nor to replace any drug prescribe by a physician. We believe that such an act may be detrimental to the health and well being of an individual and that dietary supplements should only be used in a supportive role in such conditions.
8.	_____Initials	I am fully aware and agree that there are **POSSIBLE RISKS OF REMAINING UNMANAGED OR SUPPORTED:** Delay of management and support allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of management and support will complicate the condition and make future rehabilitation more difficult. We will always provide you with our best care; and, if results are suboptimal or finding indicate, we will refer you to another provider who will assist you with your condition.
9.	_____Initials	I agree that no pictures and or videos in analog or digital form will be allowed without the express written permission of Dr. Rosenthal.
10.	_____Initials	I affirm and agree that I am indeed the patient or guardian/ward listed in this paperwork and do affirm that I/we have the listed health complaints and I/we are not part of an investigatory body including local, state or federal commissions involved with health care, legal bodies, insurance investigators, chiropractic and/or medical boards and investigations.
11.	_____Initials	I affirm and agree that I have received a dated copy of this authorization for care form.

Patient Name: _____Date:_____ (Please Print)

Patient Signature: _____Date:_____

Signature of Parent or

Legal Guardian/Ward: _____Date:_____