



Tyler Leopardi D.C. , Brittany Leopardi D.C.
1933 S. Narcoossee Rd. Saint Cloud, FL 34771
P: 321.430.3820 F:1.407.498.4051
info@avenueonechiropractic.com

PEDIATRIC INTAKE FORM

Build A Healthy Foundation.

Welcome to the Avenue One Chiropractic community!

- Please initial the top corner of each page.
- For any question that does not apply to your child, simply respond "N/A" for Not Applicable.

Today's Date: _____

Has your child ever received chiropractic care? No Yes, (Please list the City, State, & Doctor): _____

Has anyone in your child's family ever received chiropractic care? No Yes, (Please list the City, State, & Doctor): _____

Who can we thank for referring you to our office? _____

PERSONAL INFORMATION

Child's Full Name: _____

Child's Preferred Name: _____

Male Female

Weight: _____lb. _____oz. Height: _____ft. _____in.

Date of Birth: _____ Age: _____

Address: _____

City: _____ State: _____

Zip: _____

List Your Child's Regular Physical Activities:

List Your Child's Hobbies & Interests:

List The Name(s) & Age(s) of Your Child's Sibling(s):

Full Name of Parent/Guardian #1:

Phone: _____ Home Work Cell

Cell Phone Provider: _____

Email: _____

Occupation: _____

Employer: _____

Full Name of Parent/Guardian #2:

Phone: _____ Home Work Cell

Cell Phone Provider: _____

Email: _____

Occupation: _____

Employer: _____

Family Member(s) Responsible For Finances:

Parent/Guardian #1 Parent/Guardian #2

Both Parents/Guardians #1 & #2

Other: _____

Other's Phone #: _____

INSURANCE INFORMATION

Select which is true for you: Self Pay Insured with Medicare, (Please record your Medicare information)

Primary Insurance: _____

Member ID #: _____

Policy Holder's Name: _____

Policy Holder's Date of Birth: _____

Policy Holder's Employer: _____

Secondary Insurance: _____

Member ID #: _____

Policy Holder's Name: _____

Policy Holder's Date of Birth: _____

Policy Holder's Employer: _____

HEALTH GOALS

Select all of the current health and lifestyle goals for your child:

- | | | |
|---|---|---|
| <input type="checkbox"/> Improve Posture | <input type="checkbox"/> Improve Focus/Concentration | <input type="checkbox"/> Improve Athletic Performance |
| <input type="checkbox"/> Get Adequate Sleep | <input type="checkbox"/> Increase Self Confidence | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Drink More Water | <input type="checkbox"/> Restore Emotional Health | _____ |
| <input type="checkbox"/> Increase Energy | <input type="checkbox"/> Strengthen Immune System | _____ |
| <input type="checkbox"/> Improve Diet/Nutrition | <input type="checkbox"/> Maintain Healthy Body Weight | _____ |

CASE HISTORY

Does your child have any genetic disorders or disabilities? No Yes, (Explain): _____

Has your child ever had a serious illness or health emergency? No Yes, (List all condition(s) including the year): _____

Has your child ever had an operation? No Yes, (List all operation(s) including the year): _____

Has your child ever been in an auto accident? No Yes, (Include the year): _____

Has your child ever been unconscious? No Yes, (Explain): _____

Has your child ever fractured a bone? No Yes, (Explain): _____

Does your child have any allergies? No Yes, (Explain): _____

Has your child ever taken an antibiotic drug? No Yes, (Include times per lifetime): _____

Is your child taking any over-the-counter or prescription drug, vitamin / supplement, or natural remedy?

No Yes, (Please list the name & reason for taking): _____

PRENATAL HISTORY

Complete this section if your child is younger than 5 years of age.

Name of Obstetrician / Midwife: _____

Ultrasounds during pregnancy? No Yes, (How many?): _____

Complications during pregnancy / delivery? No Yes, (Explain): _____

List any drug / medication, vitamin / supplement, or natural remedy taken during pregnancy / delivery: _____

Location of birth: Hospital Birthing Center Home Other: _____

Childbirth delivery method: Vaginal Planned Cesarean Section Emergency Cesarean Section

Vaginal Birth After Cesarean Vacuum Extraction Forceps

Birth Weight: _____ lb. _____ oz. Birth Length: _____ ft. _____ in. APGAR Scores: _____ - _____

Was / is your child breast fed? No Yes, (For how long?): _____

Was / is your child formula fed? No Yes, (For how long?): _____ Formula type: _____

Was your child introduced to cow's milk? No Yes, (At what age?): _____

According to the National Safety Council, approximately 50% of children fall head first from a high place during their first years of life (i.e. a bed, changing table, down stairs) Did your child have a fall similar to this?

No Yes, Explain: _____

CURRENT SYMPTOMS

Select which is true for your child:

My child **DOES NOT** have symptoms. I am seeking chiropractic care for my child to maintain wellness.

(If above is selected, move ahead to the "INITIAL ASSESSMENT" section)

My child **DOES** have symptoms.

Select all of the symptom(s) that has you seeking chiropractic care for your child:

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> ADHD/ADD | <input type="checkbox"/> Autism | <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Restless Sleep |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Back Pain | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Scoliosis |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Bed Wetting | <input type="checkbox"/> Growing Pains | <input type="checkbox"/> Temper Tantrums/Moody |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Colic | <input type="checkbox"/> Headaches | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Athletic Injury | <input type="checkbox"/> Digestive Problems | <input type="checkbox"/> Recurring Colds/Fevers | _____ |

When did your child's symptom(s) begin? Today Days Ago Weeks Ago Months Ago Years Ago

Did your child's symptom(s) begin as a result of an injury? No Yes, (Explain): _____

What have you already tried that **HAS NOT** helped to relieve your child's symptom(s)? _____

What have you already tried that **HAS** helped to relieve your child's symptom(s)? _____

INITIAL ASSESSMENT

NAME: _____ DATE: _____

Select which is true for your child.

- My child **DOES NOT** have symptoms. (If selected, move ahead to the "STRESS ASSESSMENT" section.)
- My child **DOES** have symptoms. (If selected, use the "EFFECT SCALE" ranking to answer the statements below.)

EFFECT SCALE

										
0	1	2	3	4	5	6	7	8	9	10
NO EFFECT	MILD EFFECT			MODERATE EFFECT			LIMITING EFFECT			SEVERE EFFECT
I am free from any symptom. I can do all of my daily activities. My quality of life is good. I am grateful for my good health.	I barely notice the symptom. I can do most of my daily activities. I don't think much about the symptom, but it does cause me some discomfort.			I notice the symptom and it causes me distress. I can do some of my daily activities. I can only ignore the symptom for a short period of time.			I experience constant distress from the symptom. I am unable to do many of my daily activities. I can not ignore the symptom, it disrupts my ability to think clearly, hold a job, and maintain social relationships.			I am in distress and excruciating pain from the symptom. I am unable to do any of my daily activities. I am weak, delirious and bedridden. (Very few people ever experience this level of pain. Suicide is often considered.)

Use the 0-10 "EFFECT SCALE" ranking above to base your answer for each statement below. List your child's symptom, then read each statement and place an "X" in the box to mark your rating.

List your child's main symptom here: _____	0	1	2	3	4	5	6	7	8	9	10
ON AVERAGE, rate the effect of your symptom.											
RIGHT NOW, rate the effect of your symptom.											
AT ITS BEST, rate how close to "0" your symptom gets.											
AT ITS WORST, rate how close to "10" your symptom gets.											
If your child has another symptom, List it here: _____	0	1	2	3	4	5	6	7	8	9	10
ON AVERAGE, rate the effect of your symptom.											
RIGHT NOW, rate the effect of your symptom.											
AT ITS BEST, rate how close to "0" your symptom gets.											
AT ITS WORST, rate how close to "10" your symptom gets.											
If your child has another symptom, List it here: _____	0	1	2	3	4	5	6	7	8	9	10
ON AVERAGE, rate the effect of your symptom.											
RIGHT NOW, rate the effect of your symptom.											
AT ITS BEST, rate how close to "0" your symptom gets.											
AT ITS WORST, rate how close to "10" your symptom gets.											

* If your child has more than 3 symptoms, simply ask a team member for another form.

STRESS ASSESSMENT

Select all of the emotional, physical, and chemical stress your child has experienced in the past 3 months:

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Slip / Falls | <input type="checkbox"/> Poor Diet / Nutrition | <input type="checkbox"/> Lack of Sleep | <input type="checkbox"/> Occupational Stress |
| <input type="checkbox"/> Car Accident | <input type="checkbox"/> Excessive Sitting | <input type="checkbox"/> Death of A Loved One | <input type="checkbox"/> Financial Stress |
| <input type="checkbox"/> Sports Injury | <input type="checkbox"/> Excessive Standing | <input type="checkbox"/> Hospitalization | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Lack of Exercise | <input type="checkbox"/> Surgery / Operation | _____ |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Increase of Exercise | <input type="checkbox"/> Change In Medication | _____ |

ACTIVITIES OF DAILY LIVING

Complete if your child is older than 5 years of age. Read each activity listed below and place an "X" in the box to rate if your child feels any symptom(s) when doing the activity. Use the 0-10 "EFFECT SCALE" from the previous page to base your rating. Select "N/A" for any activity Not Applicable to your child.

0	1	2	3	4	5	6	7	8	9	10
NO EFFECT	MILD EFFECT			MODERATE EFFECT			LIMITING EFFECT		SEVERE EFFECT	

PERSONAL HYGIENE & DAILY CARE

ACTIVITY	RATING										ADDITIONAL NOTES:		
	N/A	0	1	2	3	4	5	6	7	8		9	10
Bathing / Showering													
Grooming Hair													
Brushing Teeth													
Using The Toilet													
Dressing The Upper Body													
Dressing The Lower Body													

DAILY PHYSICAL ACTIVITIES

ACTIVITY	RATING										ADDITIONAL NOTES:		
	N/A	0	1	2	3	4	5	6	7	8		9	10
Standing													
Sitting													
Squatting													
Kneeling													
Reaching Overhead													
Bending Forward													
Turning Left													
Turning Right													
Move From Lying to Sitting													
Move From Sitting to Standing													
Move From Standing to Sitting													

FUNCTIONAL ACTIVITIES

ACTIVITY	RATING										ADDITIONAL NOTES:		
	N/A	0	1	2	3	4	5	6	7	8		9	10
Sleeping													
Eating													
Going Up & Down Stairs													
Getting In & Out of Car													
Driving													
Using A Computer													
Focusing/ Concentrating													
Preparing Food													
Household Chores													
Lifting Children													
Carrying Bag / Purse													

SOCIAL, RECREATIONAL, & OTHER ACTIVITIES

ACTIVITY	RATING										ADDITIONAL NOTES:		
	N/A	0	1	2	3	4	5	6	7	8		9	10
Competitive Sports													
Running / Jogging / Hiking													
Other Recreation Activities													
Hobbies													
Sexual Activity													

FAMILY HEALTH HISTORY

Place an "X" in the box below to show if your child's family members have ever had the following conditions.

- If there is more than one family member per category, use an "X" to represent each individual.
- If you are filling this form out for your child, use "SELF" to represent your child's conditions.

CONDITION	SELF	SIBLING(S)	FATHER	MOTHER
Acid Reflux / Heartburn / GERD				
ADD / ADHD				
Allergies				
Anxiety				
Arthritis / Joint Pain				
Asthma / Difficulty Breathing				
Bed Wetting				
Birth Defect				
Cancer				
Colic				
Convulsions / Epilepsy				
Deceased				
Depression				
Diabetes				
Digestive Problems				
Disc Problems				
Ear Problems / Hearing loss				
Fibromyalgia / Muscle Pain				
Frequent Cold / Flu				
Gall Bladder Problems				
Headache / Migraines				
Heart Problems				
High / Low Blood Pressure				
HIV / AIDS				
Impotence / Sexual Dysfunction				
Kidney Problems				
Learning Disability				
Liver Problems				
Menstrual Dysfunction				
Mood Changes / Irritable				
Neck Pain / Back Pain				
Prostate Problems				
Sciatica				
Scoliosis				
Sinus / Drainage Problems				
Skin Problems				
Sleep Problems				
Thyroid Problems				
Tremors				
Vertigo / Dizziness				
Vision Problems				
Other:				

TERMS OF ACCEPTANCE

Here at Avenue One Chiropractic the term **Practice Member** is used instead of “patient” as “patient” suggests illness or injury, and many whom we serve are healthy and seeking wellness rather than symptom management. A Practice Member is an active participant in his or her chiropractic care, and is therefore invited to ask any questions or express any concerns that he or she may have. Practice Members can expect quality service and leadership as they regain control of their health. With the utilization of state of the art advanced technology, a complete analysis of your child’s spine will be administered first to detect the presence of vertebral subluxation complex and to monitor your child’s progress. Please read and sign this form stating that you understand the items explained below. If there is anything that is unclear please ask questions before you sign. If you refuse to sign this form, the doctor reserves the right to refuse care.

INFORMED CONSENT FOR CHIROPRACTIC CARE

I hereby consent to give the doctor(s) of chiropractic, and anyone working in the Avenue One Chiropractic office authorized by the chiropractor(s), permission and authority to care for my child (the minor listed here: _____ for whom I am legally responsible). Chiropractic tests, diagnosis, analysis, and adjustments are very safe and beneficial and rarely cause any risks. In rare cases, underlying physical defects, deformities or pathologies may make your child prone to injury. It is the responsibility of the child’s parent/guardian to make it known, or to learn through health care procedures if your child is suffering from latent pathological defects, illnesses, or deformities, which would otherwise not come to the attention of the chiropractor(s). The doctor(s) of chiropractic will not give any treatment or care if he or she is aware that such care should not be used for a particular condition or circumstance. Your child’s doctor(s) of chiropractic are licensed primary care provider(s), and is available to work with all other types of providers. I understand that if my child is accepted as a Practice Member at Avenue One Chiropractic, I am authorizing them to proceed with any treatment that they deem necessary. I understand that following the doctor(s) recommend care plan is essential to maximizing my child’s healing and reaching optimal health through chiropractic. Furthermore, any questions that I have regarding chiropractic care, will be explained to me upon my request.

AUTHORIZATION FOR X-RAYS

Specific postural x-rays may be necessary for the identification of the location, type, and severity of vertebral subluxation, as well as for the diagnosis and identification of latent or dangerous conditions requiring medical attention. X-rays may also be used to show progress after a period of recommended chiropractic care. At your request, you can received a copy of your child’s x-rays to a disc for the mandated fee of \$15.00.

By signing this page below, I authorize Avenue One Chiropractic to perform diagnostic x-rays of my child if medically necessary.

Select which is true for your female child:

- To the best of my knowledge, there is no chance that my child is pregnant at this time.
- I know or believe that my child may be pregnant at this time and therefore I **DO NOT** authorize Avenue One Chiropractic to perform diagnostic x-rays of her.

AUTHORIZATION FOR RELEASE OF INFORMATION & ASSIGNMENT OF BENEFIT

By signing below, I recognize that I am financially responsible for all services rendered to my child regardless of insurance or benefit. I understand that Avenue One Chiropractic, is primarily a cash-office and that I will have to pay for the full cost for my child’s services up front and that I am responsible for submitting any insurance claim to request reimbursement. I recognize that any health insurance policy is an arrangement between me and my child’s insurance carrier. I hereby authorize Avenue One Chiropractic to release all necessary information concerning my child’s health condition to any billing company, insurance company, attorney, and/or adjuster in order to process any claim for reimbursement of charges incurred by my child. In addition I authorize Avenue One Chiropractic to release any information regarding my child’s health condition to other health care providers involved in my child’s care. This assignment will remain in effect until revoked by me in writing. I agree that a photocopy of this form is to be considered as valid as the original. I confirm that all information I have provided is true and correct to the best of my knowledge. I confirm that I have read and fully understand this agreement and authorize Avenue One Chiropractic to proceed with chiropractic care.

Signature of Practice Member or Parent/Guardian

Date

NOTICE OF PRIVACY PRACTICES

This notice describes how health information about your child may be used and disclosed and how you can get access to your child’s health information and records.

Avenue One Chiropractic, understands the importance of privacy and we are committed to maintaining the confidentiality of your child’s protected health information (PHI) in compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). We have developed office policies and procedures that protect your child’s personal and health information when used within our office and any devices used to copy or transfer this data. We assure you that your child’s information will only be shared as required and only for the purpose of administering your child’s case and obtaining payment for services. Be assured that without your permission, your child’s health information will not be used for any other purpose.

The following ways are how your child’s PHI may be used within our office to provide you the best care and services possible:

- To provide treatment, obtain payment, and conduct health care operations.
- To schedule appointments and send reminders.
- To communicate with your child’s family, friends, and/or caregivers with your authorization.
- As permitted or required by the law.
- For certain activities when the law requires it.

The following describes your rights regarding your child’s (PHI). You may:

- Request to inspect any copy of your child’s records.
- Request to amend incomplete or inaccurate information in your child’s records.
- Receive an accounting of certain disclosures of your child’s health information.
- Ask for additional privacy protections (although your request may be declined).
- Ask for confidential communications in a particular manner.
- Receive a paper copy of this Notice.
- File a complaint without penalty

Avenue One Chiropractic reserves the right to change this privacy policy as allowed by law and to make the new notice apply to health information already received as well as any information received in the future. A copy of our current notice is available upon request. The notice will contain the effective date.

If you believe that we have not properly respected the privacy of your child’s PHI, you may file a complaint with our office by calling 321.430.3820, sending a letter to our office address, 1933 S. Narcoossee Rd. Saint Cloud, FL 34771 or by emailing info@avenueonechiropractic.com.

I confirm that I have received and reviewed this notice and understand how health information about my child may be used and disclosed and how I can get access to my child’s health information and records.

Signature of Practice Member or Parent/Guardian _____

Date _____

TESTIMONIAL CONSENT

IN OFFICE	I DO	I DO NOT
Photographs		
Written Testimonials		
Video Testimonials		
My Child’s First Name		
ON SOCIAL MEDIA	I DO	I DO NOT
Photographs		
Written Testimonials		
Video Testimonials		
My Profile Name		

Avenue One Chiropractic is happy to celebrate and display written testimonials, photographs, and videos in our office and on our social media outlets to educate others about the benefits of chiropractic.

Place an “X” in the boxes to the left to select your preferences.

- Selecting **I DO** authorizes Avenue One Chiropractic to display the item.
- Selecting **I DO NOT** does not authorize Avenue One Chiropractic to display the item.

Attending Doctor’s Signature _____

Date _____