Meinecke Chiropractic & Lifestyle Center
Helping Humans Thrive

meineckechiropractic.com

New Patient EHR

Intake Form

Name: _____ Date: _____

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ White (Caucasian)
☐ Native Hawaiian or Pacific Islander ☐ Other ☐ Decline to Answer

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline to Answer

Smoking Status: ☐ Every Day Smoker ☐ Occasional Smoker ☐ Former Smoker ☐ Never Smoked

Date Began Smoking (put n/a if you have never smoked): _____

Are you currently taking any medications? (Please include regularly used over the counter medications) ☐ No ☐ Yes

If yes, please list them here:

Medication Name	***Dosage and Frequency (i.e. 5mg once a day, etc.)***

Do you have any medication allergies? ☐ No ☐ Yes

If yes, please list them here:

Medication Name	***Reaction***	***Onset Date***	***Additional Comments***

Height: _____ Weight: _____ Blood Pressure: _____ / _____ Heart Rate: _____

_____ _____
Patient Signature Date

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meineckechiropractic.com

Child

Wellness Profile

Practice Member Information

File Number _____

Appointment Date: _____

Child's Name: _____ **Male / Female**
Last First M.I.

Prefer to Be Called: _____ Social Security #: _____ - _____ - _____

Parents'/Guardians' Names: _____

Child's Birth Date: _____ Age: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Parent's Cell Phone: _____

Parent's Email: _____ Social Security #: _____ - _____ - _____

Name(s) and Age(s) of Siblings: _____

Preferred Language: _____

In case of an emergency, whom should be notified? _____ Phone: _____

How did you hear about us? _____

Whom may we thank for referring you? _____

Payment Information

Guardian Information

Name: _____ Birth Date: _____

Billing Address: _____
Street City State Zip

Employer: _____ Work Phone: _____ Social Security #: _____ - _____ - _____

Insurance Information

Primary: _____ Secondary: _____

Policy Number: _____ Policy Number: _____

I (we) agree to pay for services rendered to the above-mentioned patient as the charge is incurred. I (we) understand that health and accident insurance policies are arrangements between an insurance carrier and myself and that I am personally responsible for payment of any and all services, covered or not covered. If the doctor is a contracted provider for my managed care plan, I understand I am responsible for all copayments and non-covered services. I also understand and agree to pay all copays and fees for non-covered services prior to seeing the doctor. I understand that if I terminate my care and treatment, any fees for services beyond thirty days are subject to a 1.5% monthly finance charge (18% annually).

I (we) authorize the doctor and his staff to release any information deemed appropriate concerning my physical condition to any insurance company, claims adjuster, case nurse, claims reviewer, employer, health care provider or attorney in order to process a claim for reimbursement or charges incurred by me as a result of professional services rendered and hereby release him/her of any consequences thereof. I agree that a Photostatic copy of this agreement shall serve as the original.

Guardian's Signature: _____ Date: _____

I have read and agree to the above statements.

Wellness Profile

The human body is designed to be healthy. The primary system in the body which coordinates health and function is the nervous system. Your nervous system is surrounded and protected by the bones of the spine, called ***vertebrae***. Many of the common health challenges that adults experience have their origins during the ***developmental years***, some starting at birth. Layers of damage to the spine and ***nervous system*** occur as a result of various ***traumas, toxins, and emotional stress***. The result may be misalignment to the spinal column and damage to the nervous system in a condition called ***Vertebral Subluxation***. Please answer the following questions to give us a better understanding of your child's state of wellness and factors which may be contributing to vertebral subluxation and impeding your child's ***ability to heal***.

What signals has your child's body been communicating?

CURRENT	PREVIOUS		CURRENT	PREVIOUS		CURRENT	PREVIOUS	
☐	☐	Asthma	☐	☐	Frequent Diarrhea	☐	☐	Failure to Thrive / Slow Weight Gain
☐	☐	Respiratory Tract Infections	☐	☐	Constipation	☐	☐	Slow or Absent Reflexes
☐	☐	Sinus Problems	☐	☐	Flatulence	☐	☐	Asymmetrical Crawling or Gait
☐	☐	Ear Infections	☐	☐	Headaches / Migraines	☐	☐	Weight Challenges
☐	☐	Tonsillitis	☐	☐	Neck Pain	☐	☐	Bed Wetting
☐	☐	Strep Throat	☐	☐	Torticollis / Head Tilt	☐	☐	Sleep Problems
☐	☐	Frequent colds / Croup	☐	☐	Trouble Feeding	☐	☐	Night Terrors
☐	☐	Recurrent Fevers	☐	☐	Back Pain	☐	☐	Tip Toe Walking
☐	☐	Eczema	☐	☐	Growing Pains	☐	☐	Regression of Milestones
☐	☐	Rashes	☐	☐	Scoliosis	☐	☐	Seizures
☐	☐	Allergies	☐	☐	Swollen, Painful Joint	☐	☐	Tremors / Shaking
☐	☐	Food Sensitivities	☐	☐	Colic	☐	☐	ADD / ADHD
☐	☐	Digestive Problems	☐	☐	Frequent Crying Spells	☐	☐	Autism / PDD

Do you have a specific concern that brings you in?

☐ No, I'm interested in having my child's nervous system assessed to achieve optimal health and functioning

☐ Yes: _____

If yes, please answer the following questions:

Does your child appear to be in pain or discomfort? _____ How long has your child been experiencing this?_____

Is it getting better, worse, or staying the same? _____ Was the onset sudden or gradual? _____

Have you seen other health professionals regarding this complaint? ☐ No ☐ Yes, whom? _____

Has your child taken any medication for this complaint? ☐ No ☐ Yes _____

Has your child ever experienced this complaint before? ☐ No ☐ Yes _____

Did they receive any treatment at the time? ☐ No ☐ Yes _____

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Child

Wellness Profile

Prenatal Profile

☐ Adopted ☐ Prenatal history unknown ☐ Birth history unknown
Complications during pregnancy? ☐ No ☐ Yes _____
Ultrasounds during pregnancy? ☐ No ☐ Yes If so, how many? _____
Medications during pregnancy? ☐ No ☐ Yes _____
If so, which ones and how often? (include OTC) _____
Exposure to alcohol, cigarettes, or second hand smoke during pregnancy? ☐ No ☐ Yes _____

Birth Experience

Location of Birth: ☐ Home ☐ Hospital ☐ Birthing Centre ☐ Other _____
Birth Attendants: ☐ Doula ☐ Midwife ☐ GP ☐ OB ☐ Other _____
Medications during labor / delivery? (including IV antibiotics) ☐ No ☐ Yes _____
Was Pitocin used to induce / speed up labor? ☐ No ☐ Yes
Were your membranes ruptured by a medical professional? ☐ No ☐ Yes
Was your child at anytime during your pregnancy in an intra-uterine constraining position? ☐ No ☐ Yes ☐ Unsure
If yes, please describe: ☐ Breech ☐ Transverse ☐ Face / Brow presentation
Was your delivery vaginal or C-section? _____ If C-section, was it planned or emergency? _____
If vaginal, was the baby presented: ☐ Head ☐ Face ☐ Breech
Were any of the following interventions used during delivery? ☐ Forceps ☐ Vacuum ☐ Extraction ☐ Other
Were there any complications during delivery? ☐ No ☐ Yes _____
How long was the labor from the first regular contractions to the birth? _____ hours
How long was the second stage (the pushing phase) of the labor? _____ hours
Was the baby born with any purple markings / bruising on their face or head? ☐ No ☐ Yes
Any concerns about misshapen head at birth? ☐ No ☐ Yes

Post Natal & Infant History

How many weeks gestation was the baby at birth? ____w ____d / Birth Weight: ____lbs ____oz / Birth Length: ___in
Was the baby ever administered to Intensive Care? ☐ No ☐ Yes, for how long and why? _____
Was any medication given to the baby at birth? ☐ No ☐ Yes, what medication and why? _____
Was your child exclusively breastfed? ☐ No ☐ Yes, _____ months
Was your child breastfed + formula fed? ☐ No ☐ Yes _____ months
Did your child show any sensitivities to formula (reflux, eczema, arching back, frequent spit up)? ☐ No ☐ Yes
What age did you introduce solid foods to your child? _____ months
Did you introduce cereal or grains within your child's first year? ☐ No ☐ Yes
Did / Do you practice attachment parenting methods? (cosleeping, elimination communication, feeding on demand, extended breastfeeding, etc.) ☐ No ☐ Yes
Did your child spend excess time in any baby devices? (bouncer seats, swings, bumbos, car seats, etc) ☐ No ☐ Yes

Physical Traumas

Has your child ever fallen from high places? ☐ No ☐ Yes _____
Has your child ever been involved in a motor vehicle accident? ☐ No ☐ Yes _____
Has your child broken any bones? ☐ No ☐ Yes _____
Has your child had any previous hospitalizations? ☐ No ☐ Yes _____
Has your child had any previous surgeries? ☐ No ☐ Yes _____
Does your child spend time using a tablet, computer, or video games? ☐ Never ☐ Rarely ☐ Daily ☐ Several Hrs/Day
Does your child watch TV? . . . . . ☐ Never ☐ Rarely ☐ Daily ☐ Several Hrs/Day
Does your child exercise? . . . . . ☐ No ☐ Daily ☐ Weekly ☐ Seasonally
Does your child play contact sports? . . . . . ☐ No ☐ Daily ☐ Weekly ☐ Seasonally
Does your child sleep on their. . . . . ☐ Back ☐ Belly ☐ Sides (Both, Right, Left)
Does your child carry a backpack? . . . . . ☐ No ☐ Yes
Does it weigh less than 15% of their body weight? . . . . . ☐ No ☐ Yes
Do they wear their back pack on two shoulders? . . . . . ☐ No ☐ Yes
Does your child show excessive or uneven shoe wearing out? . . . . . ☐ No ☐ Yes
Does your child wear custom orthotics? ☐ No ☐ Yes, for what purpose? _____

Chemical Stressors

Have you chosen to vaccinate your child? . . . . . ☐ No ☐ Yes, on a delayed schedule ☐ Yes, on schedule
Any adverse reactions to vaccines? . . . . . ☐ No ☐ Yes _____
Does your child receive annual flu shots? . . . . ☐ No ☐ Yes
Does your child take any antibiotics? . . . . . ☐ No ☐ Yes If yes, how often? _____
How many glasses of water/day? . . . . . ☐ 0 ☐ 1-3 ☐ 4-6 ☐ 7-9 ☐ 10+
How many glasses of caffeinated beverages/day? . . . ☐ 0 ☐ 1-4 ☐ 4-6 ☐ 7-9 ☐ 10+
How many glasses of cow's milk, juice and pop/day? ☐ 0 ☐ 1-4 ☐ 4-6 ☐ 7-9 ☐ 10+
Does your child eat gluten? . . . . . ☐ Yes ☐ No ☐ Trying to eliminate from diet
Does your child eat dairy? . . . . . ☐ Yes ☐ No ☐ Trying to eliminate from diet
Does your child eat refined sugars? (white sugar, white bread, etc.) ☐ Yes ☐ No ☐ Trying to eliminate from diet
Does your child eat boxed/frozen foods? . . . . . ☐ Yes ☐ No ☐ Trying to eliminate from diet
Does your child eat artificial sweeteners? (Splenda, Diet Pop, etc.) ☐ Yes ☐ No ☐ Trying to eliminate from diet
Any food/drink allergies, sensitivities, intolerances? ☐ No ☐ Yes _____
Is your child exposed to second hand smoke? ☐ No ☐ Yes _____
Does your child take a probiotic daily? ☐ No ☐ Yes, _____CFU's/day
Does your child take vitamin D3 daily? ☐ No ☐ Yes, _____ IU's/day
Does your child take Omega 3 Fish Oils daily? ☐ No ☐ Yes, _____mg/day Capsule Liquid
Other supplements or homeopathics? _____

Goals and Consent

What is your primary goal for your child at our clinic? _____

Our goals are to provide a detailed assessment of your child's current health status and provide to you the resources for a highly engaged and healthy child whose body is functioning at its absolute peak potential. Essential to this is a healthy nervous system functioning free from interference called subluxations. You've taken an important step for your child's health through a chiropractic evaluation!

Consent to Evaluation of a Minor Child:

I _____ being the parent or legal guardian of _____(minor) hereby grant permission for my child to receive a chiropractic evaluation including history, spinal scan, and examination. Any findings will be communicated before consenting to commencement of care, if appropriate.

_____ _____

Consenting Adult's Signature Date

☐ I choose to decline receipt of my clinical summary after every visit (These summaries are often blank as a result of the nature and frequency of chiropractic care).

Notice of Privacy

This notice describes how healthcare information about you may be used and disclosed and how you can get access to this information. Please read this carefully.

This office abides by the terms described in this policy.

Meinecke Chiropractic uses and discloses your protected health care information for the following reasons:

- To share with other treated healthcare providers regarding your healthcare
- To submit to insurance companies or Worker's Compensation Claim to verify that treatment has been rendered
- To determine patient's benefits in a healthcare insurance plan
- Releasing information required by State or Federal Public Health Law
- To assist in overcoming language barriers when caring for a patient
- Business associates providing written assurances for your privacy have been attained
- Emergency times
- Abuse, neglect, or domestic violence
- Appointment reminders to the household or answering machines
- Sign-In sheets may be disclosed to verify office visits

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

You have the right to:

- Revoke authorization, in writing at any time by specifying what you want restricted and to whom
- Speak to our privacy officer who is: Dr. Jason Meinecke and can be reached at: (308) 381-8299 regarding privacy issues
- 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
- To render a complaint to our privacy officer or to the Secretary of Health and Human Services

This office reserves the right to change the terms of this notice and to 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 office staff.

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

_____

Patient's Name (Print) Patient's / Guardian's Signature Date