Date: _____

knutson CHIROPRACTIC

12631 Fremont Ave #5, Zimmerman, MN 55398
763.482.5167 office@knutsonchiro.com

Infant Intake Form: Newborn to 1 yr.

Child's Name: _____ Name the child prefers to be called:

_____ Name of Mom, Dad, or

guardian:_____ Address:

_____ DOB: _____Age:____ Gender: M F City:

_____ State: ____ Zip: _____ Home #: _____Cell #: _____

Family E-mail: _____

Best place to reach you: ◊ Home ◊Cell ◊Work: ( )_____ext:_____

Children's Siblings and ages (if applicable):_____

Who is your child's primary care doctor? _____
(Please list the name of your child's doctor and the facility)

May we contact him or her about your care? Y N Were you referred by him or her? Y or N

How did you hear about us?_____

Insurance Information

Are your child's symptoms related to an accident? Y N □Automobile □Work □Other Date: ____/____/____

_____

Current Complaints

Major complaints and symptoms: 1)_____

2)_____

3)_____

How do you believe the child's problem or pain began?_____

_____

Has your child seen any provider for this condition? **What did they do, and did it help?**

1._____ _____ **Y N**

2._____ _____ **Y N**

Vitamins and Supplements	**Allergies**	**Medications**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

During the Pregnancy, Did you use or have any of the following:

Tobacco . . . . . ☐ No ☐ Yes: _____

Alcohol . . . . . ☐ No ☐ Yes: _____

High Blood Presure . . . . . ☐ No ☐ Yes: _____

Diabetes (Type1, Type 2, or Gestational) . . . . . ☐ No ☐ Yes: _____

Anemia . . . . . ☐ No ☐ Yes: _____

Please Check Any of the Following that Occurred While Pregnant With This Child:

	No	Yes	Describe
Falls	☐	☐	_____
Motor Vehicle Accidents	☐	☐	_____
Morning Sickness/Nausea	☐	☐	_____
Indigestion	☐	☐	_____
Seizures	☐	☐	_____
Swollen Ankles	☐	☐	_____
Thyroid Problems	☐	☐	_____
Heart Problems	☐	☐	_____
Low Back Pain	☐	☐	_____
Headaches	☐	☐	_____
Rib / Breathing Pain	☐	☐	_____
Abnormal Bleeding	☐	☐	_____
Premature Contractions	☐	☐	_____
Bed Rest	☐	☐	_____
Pre-eclampsia	☐	☐	_____
Any Other Illnesses	☐	☐	_____

Please Answer the Following Questions: **(if the answer is yes, please describe briefly)**

Was this child born Premature? N Y If yes, at what week was your child born?_____

Were there complications with your child's health following delivery? N Y:_____

Has your child experienced any significant illnesses? N Y

If yes, please list the illnesses your child has experienced: _____

_____

Have you noticed any unusual rashes or markings? N Y: _____

Does your child experience ear aches or redness around the ears? N Y

Has your child had an ear infection? N Y If yes, how many?_____

Has your child had antibiotics? N Y If yes, how many treatments?_____

Has your child been vaccinated? N Y

If yes, when was your child's last vaccination?_____

Any problems with Constipation? N Y:_____

Any problems with Diarrhea? N Y:_____

Has your child received chiropractic care before? N Y If yes, when was their last treatment?_____

Has your child had any significant illnesses? N Y: RSV, Bronchitis, Pneumonia, Acid Reflux

Do you have any other concerns regarding your child's health?_____

_____

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Terms of Acceptance

VERBAL SUBLUXATION: A misalignment of one or more of the 24 vertebra in the spine, or within the extremities, which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral and extremity subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

**** Possible Adverse Reactions to an Adjustment****

Soreness: I am aware that like exercise it is common to experience muscle soreness in the first few treatments.

Dizziness: Temporary symptoms like dizziness and nausea can occur but are relatively rare.

Fractures/Joint Injury: I further understand that in isolated cases underlying physical defects, deformities or pathologies like weak bones from osteoporosis may render the patient susceptible to injury. When Osteoporosis, degenerative disk, or another abnormality is detected, this office will proceed with extra caution.

Stroke: Although strokes happen with some frequency in our world, strokes from chiropractic adjustments are rare. I am aware that nerve or brain damage include stroke is reported to occur once in one million to once in ten million treatments.

Nutritional Supplements: If I have a medical condition and taking prescription medication, I agree to discuss with my medical doctor any nutritional supplementation that has been prescribed or taken from Knutson Chiropractic.

I have read and fully understand the above statements.
All questions regarding the doctor's objectives pertaining to the care in this office have been answered to my complete satisfaction.
I, therefore, accept chiropractic care on this basis.

Signature: _____ Date: _____/_____/_____

HIPPA Regulations Knutson Chiropractic Will Follow to Ensure your Protection

Your Rights:

- The right to request restriction on certain uses and disclosure of your protected health information, including those related to disclosure to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree to a requested restriction.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.

In 2009 all healthcare professionals are required by law to send their bills, correspondence, and related billing information electronically. Knutson Chiropractic uses the billing services of **Medical Business Consulting,** a company also required to follow HIPPA regulations noted by the Dept. of Health and Human Services (federal level). Information that will be electronically submitted is: *Beneficiary's name, date of birth, address, Beneficiary's health insurance identification and claim number, date(s) of service, diagnosis/nature of illness, procedure/services performed.*

Contact information:

If you think your privacy rights have been violated by us, or disagree with a decision we made about access to your personal health information, you may contact: The U.S. Department of Health & Human Services Office of Civil Rights, 200 Independence Ave. S.W., Washington, D.C. 20201 (202)619-0257 Toll Free 1-877-696-9775

I have read/received a copy of the notice of privacy practices. This acknowledgement applies to:

Signature: _____ Date: _____/_____/_____

Knutson Chiropractic Cancellation Policy

New Patients: Must give a 24 hour notice to cancel your appointment. If a 24 hour notice is not given you will be charged the rate of service which is $125.00.
Established Patients: You must call by 09:00 am on the date of your scheduled appointment. If you do not call by 09:00 am or "no show" for your appointment you will be charged the rate of service for the appointment that you scheduled.
Exceptions: Medical Emergencies, Illness & Funerals.

Signature: _____ Date: _____/_____/_____

Financial Policy

Knutson Chiropractic is a cash based practice. Payment is due at the time of service. You may pay with HSA, FSA, Check, Credit or Cash. Receipts may be requested for you to send into your insurance company on you own. Knutson Chiropractic will not bill your insurance company.
Payment Plan: If you are suffering a financial hardship and need to set up a payment plan, please speak to our office manager at the front desk.
Returned Check Policy: All returned checks will be a $30.00 non-sufficient funds charge.

Signature: _____ Date: _____/_____/_____

Client Bill of Rights for Massage/Bodywork

I understand that the massage/bodywork I receive is provided for the basic purpose of realization and relief of muscular tension. If I experience any pain or discomfort during the session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage/bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor or other qualified medical specialist for any mental or physical ailment of which I am aware. I understand that massage practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, or prescribe or treat any physical or mental illness, and that nothing said in the course of the session given should be constructed as such. Because massage should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so. I understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment.

☐ **Please check the box indicating that you have read this policy and sign.**

Signature: _____ Date: _____/_____/_____

Patient Name: _____

****For Doctor Use Only****

PATIENT STATUS AT TIME OF INFORMED CONSENT AND TERMS OF ACCEPTANCE PROCESS

Based on my personal observations, medical history and direct conversation with the patient. I conclude that throughout the consent process the patient was:

[ ] Of Legal Age [ ] Oriented x3 [ ] Coherent and lucid
[ ] Proficient in understanding the English Language
[ ] Assisted in understanding by an interpreter (Interpreter's name _____)
[ ] Unable to give legal consent
[ ] Consent given thru legal guardian (Name)_____ (Relationship)_____

I certify that the above accurately describes the above-named patient's status during the informed consent process.

Signature of Doctor: _____ **Date:** _____/_____/_____