Chiropractic Offices of Gonstead, Stangl & Arkowski, LLC's
☐ Dr. MJ Gonstead ☐ Dr. Melissa Stangl ☐ Dr. Lisa Arkowski ☐ Dr. Jennifer Gonstead
503 E. Clairemont Avenue - Eau Claire, WI 54701 - 715-832-2223

New Patient Intake Form – PEDIATRIC (2-5 YEARS)

Date: _____

Name: _____
Address: _____
City:_____ State:_____ Zip:_____
Date of Birth: _____ □Male □Female

Parent/Guardian: _____
Address: _____
City:_____ State:_____ Zip:_____
Email: _____
Phone (home) _____
Phone (cell) _____

□ Yes □ No Does your child attend a childcare facility or in home daycare?

Previous Chiropractor: _____
Approx. Date of last visit: _____
Reason: _____

Current Medical Doctor: _____
Approx. Date of last visit: _____
Reason: _____
□ Yes - Initial:_____ □ No Do you grant us permission to contact this provider?

FAMILY HISTORY

□Yes □No Is your child adopted?

Was your child:
□Premature □Full-term □Over due
□Yes □No Difficult Pregnancy?
□Yes □No Pregnancy Complications?

□Yes □No Has there been any major life changes in your child's life recently?
If yes, how many?_____
□Yes □No Does the child have any siblings?
If yes, explain _____
□Yes □No Is there any history of family illnesses?
If yes, explain_____

PATIENT MEDICAL HISTORY

□Yes □No Has your child had any surgeries or medical procedures?
If yes, explain and please include date(s):
_____
_____

□Yes □No Has your child ever been seen on an emergency basis (ER/Urgent Care)?
If yes, explain:_____

□Yes □No Does your child have any current medical conditions?
If yes, explain:_____

□Yes □No Has your child ever been checked for tongue ties?

How many hours does your child sleep at night?
_____

□Yes □No Do you have any concerns for your child's developmental milestones?
If yes, explain:_____

□Yes □No Does your child have any persistent or recurring skin rashes?

□ Yes □ No Has your child had any ear aches?
Age:_____Frequency?_____

□Yes □No Does your child ever complain of back or neck pain?

□Yes □No Does your child ever complain of pains in the legs or arms?

□Yes □No Does your child ever complain of headaches?
Location of headaches_____
Frequency?_____

□ Yes □ No Do you notice your child has any irregular body positions/postures?

□Yes □No Does your child have any issues with potty training or bedwetting?

How often does your child have bowel movements?_____

□Yes □No Any concerns with consistency?
If yes, explain:_____

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FALLS/TRAUMA

□ Yes □ No Has your child had any recent falls or traumas?
Describe fall/trauma and date occurred_____
□ Yes □ No Has your child ever fallen from a bicycle, skateboard, scooter, rollerblades or similar?
□ Yes □ No Has your child ever fallen down stairs or fallen from a significant height?
□ Yes □ No Has your child been involved in a recent auto accident?
If yes, when?_____
□ Yes □ No Has your child ever had a bone fracture or joint dislocation?
□ Yes □ No Has your child had any other traumas or injuries?
If yes, explain:_____

NUTRITION

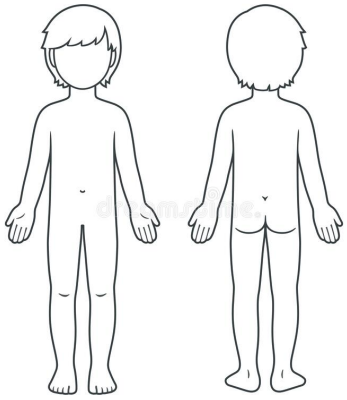
□Yes □No Was your child breast-fed?
Yes, for how long?_____
Preferred feeding side?_____
□Yes □No Is your child receiving any vitamin supplements or medications?
If yes, explain:_____
□Yes □No Does your child have any food allergies?
If yes, explain:_____

□Yes □No Do you have any concerns about your child's diet? If yes, explain:_____
What does your child usually eat for:
Breakfast?_____
Lunch?_____
Dinner?_____
Snacks?_____
Favorite food?_____
What type of fast foods does your child like to eat?_____

HISTORY OF CURRENT PRESENTATION

What is the reason you are seeking chiropractic care for your child?

□ YES □ NO Have you consulted with any other treatment/provider for this?
□ YES □ NO Are you concerned with your child having pain?
□ YES □ NO Are you concerned with any signs/symptoms your child is having?
Please Explain any YES answers:



Please indicate any areas of concern on the diagram. →

The above information is true and accurate to the best of my knowledge.
Print Child's Name: _____
Print Parent/Guardian Name:_____
Parent/Guardian Signature: _____ Date:_____

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INSURANCE INFORMATION

A ☐ Check this box if you are NOT billing insurance for your chiropractic services (Proceed to Section B)

Patient Name		Date of Birth
Patient Address		Patient Phone Number
City	State	Zip Code
Patient's Employer		Employer Phone
Insurance Company		Are you the primary Insurance Holder? Y N
If you're not the primary insurance holder, who is? (Check below)		
☐ Spouse ☐ Mother ☐ Father ☐ Other		
Policy #		Group #

Please fill out the information below if you are not the primary insurance holder		
Name of Primary		Primary's DOB
Primary's Address		Primary's Phone #
City	State	Zip Code
Primary's Employer		Employer's Phone #

Do you have secondary insurance? ☐ Yes ☐ No	
Policy #	Group #

PAYMENT AGREEMENT

I understand that there is no guarantee that my insurance companies or pre-paid health plan will cover or pay for all of my charges. Notwithstanding denial, reduction of benefits for any reason, I understand that I am responsible for all remaining charges.

Patient Signature _____ Date _____

B By signing below, I do hereby give my consent to the performance of conservative, noninvasive treatment to the joints and soft tissues. I understand that the procedures my consist of manipulations/ adjustments involving movement of the joints and soft tissues. Physical therapy exercises may also be used.

Although spinal manipulation/adjustment is considered to be one of the safest, most effective forms of therapy for musculoskeletal problems, I am aware that there are possible risks and complications associated with these procedures as follows: Soreness, Dizziness, Fractures/joint injury, Stroke, and physical therapy burns.

I understand the probability of any of these risks occuring is rare and that tests will be performed on me to minimize the risk of any complication from treatment, and I freely assume these risks. I am aware that reasonable alternatives to chiropractic procedures are available to me including rest, home application of therapy, prescription and over the counter medications, exercises, and possibly surgery. I also understand that there are beneficial effects associated with chiropractic treatment procedures including decreased pain, improved mocbility and function, and reduced muscle spasm. However, I appreciate there is no certainty that I will achieve these benefits. I agree to the performance of these procedures by my doctor and such other person(s) of the doctor's choosing. **I have read or have had read to me the above explanations of chiropractic treatment. Any question I have regarding these procedures have been answered to my satisfaction PRIOR TO MY SIGNING THIS CONSENT FORM. I have made my decisions voluntarily and freely.**

Patient Signature _____ Date_____

Office staff use only: Copy of Patient's insurance card is on file ☐ Staff Initials

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CONSENT FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Our Privacy Pledge

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information (PHI). There are several circumstances in which we may have to disclose your health care information.

• We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.

• We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.

• We may need to use your health information within our practice for quality control or other operational purposes.

• We may need to use your personal health information such as name, address, email or phone number to contact you with appointment reminders.

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before you sign this consent form (164.520). We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment or by mail. Please feel free to call us any time for a copy of our privacy notices.

Your right to limit uses or disclosures

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us.

Your right to revoke your authorization

You may revoke your consent to us at any time; however, your revocations must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

I have read your consent policy and agree to its terms. I am also acknowledging that I have received a copy of this notice, if I request it.

_____ _____

Print Patient Name Authorized Staff Representative

_____ _____

Patient or Parent's Signature Date

I WOULD LIKE A COPY OF THIS HIPAA POLICY? YES NO (CIRCLE ONE) *PAPER COPY EMAIL* (CIRCLE ONE)

503 E CLAIREMONT AVENUE * EAU CLAIRE, WI 54701 * PHONE: 715-832-2223 * FAX: 715-832-7416

Patient name: _____ DOB: _____

AUTHORIZATION FOR VERBAL COMMUNICATION

👉**Whom may we speak to on your behalf about scheduling and/or billing**

(List First and Last Names of Person(s) To Whom Your Information May Be Disclosed, Such as Parents, Spouse, Etc).

I authorize communication between :_____

_____

And the doctor(s)/staff of:

O MJ Gonstead LLC
O Arkowski Chiropractic LLC
O Stangl Chiropractic & Massage Therapy LLC
O Jennifer Gonstead Chiropractic LLC

AUTHORIZATION TO LEAVE VOICEMAIL/TEXT MESSAGES

👉**May we leave a voicemail or text about scheduling and/or billing**

O Leave Voicemail/Text at the Following Number(s)_____

Cell Phone provider: O Verizon O T-Mobile O AT&T O _____ (Other)

I authorize to leave messages with:

O Anyone O Names of authorized individuals listed above

👉This authorization will expire **one year** from date signed, unless otherwise indicated:

O Indefinite O Other end date: _____ (MM/DD/YYYY)

In accordance with the conditions listed above, I authorize the use and/or disclosure of my medical information pertaining to appointments and billing at this office. This does not authorize the release of copies of medical records.

Signature of Patient/Representative: _____

Date: _____

If signed by persons other than the patient, please print name and state relationship to patient.

Print Name: _____*Relationship:* _____

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CONSENT TO TREATMENT OF MINOR CHILD

I,_____,hereby authorize:

☐ Dr. MJ Gonstead ☐ Dr. Melissa Stangl ☐ Dr. Lisa Arkowski ☐ Dr. Jennifer Gonstead to administer chiropractic care as deemed necessary to my:

son daughter ,_____.
(Circle one) (Minor's name)

Dated this _____ day of _____, 20_____.

Parent/Guardian Signature: _____

Witness Signature: _____

☐ I consent to my child being treated when I, _____ am not present.

Signature: _____