0-3yrs old

Kinsella Chiropractic Clinic

407 South Sibley Avenue Litchfield, MN 55355
(320) 593-4494 Fax: (320) 593-4495

Child's Name: _____ DOB: _____Age: _____Sex: M F

Name of Parents/Guardians: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: _____ Social Security #: _____ Birth Weight: _____ Height: _____

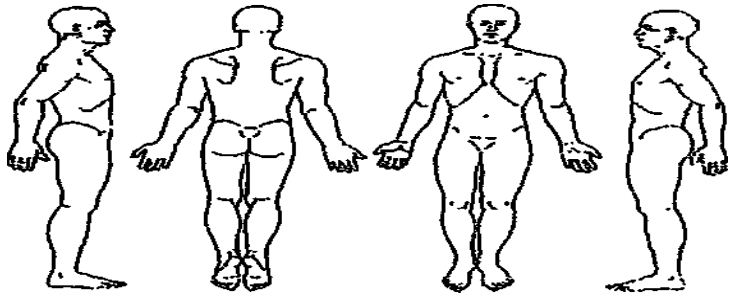
Payment Choice: Medicare Minnesota Assistance Work Comp Auto Cash Insurance Name: _____

(Make sure we get a COPY of your Health Insurance Card!)

CHIEF COMPLAINT

Mark your area of discomfort with the described sensations. Use the appropriate symbols.

XXX	Ear Infection
-----	Colic
((((	Achy Pain (AC)
:::::	Sharp Pain (SH)
00	Stiff neck
***	Other



Symptoms began on (mm/dd/yyyy): ____/_____/_____

Reason for seeking chiropractic care? _____

_____

Has your child ever seen a chiropractor before? Y N For what condition? _____

Has your child had this condition in the past? Y N If yes, when? _____

Has your child seen a Pediatrician for their current complaint? Y N Pediatrician's Name: _____

Diagnosis given: _____ Treatment: _____

Please mark any current or past problems your child has on the list below:

O Dizziness	O Allergies	O Diarrhea	O Broken Bones
O ADHD	O Runny Nose	O Poor Appetite	O Sprains/Strains
O Backaches	O Itchy Eyes	O Hyperactivity	O Hernias
O Heart Condition	O Rashes	O Behavioral	O Neck Pain
O Chronic Earaches	O Digestive	O Poor Memory	O Arm/Elbow Pain
O Diabetes	O Sinus Trouble	O Insomnia	O Leg/Hip Pain
O Tuberculosis	O Cough/Wheeze	O Bed Wetting	O Growing Pain
O Fever/Chills	O Chest Pain	O Stomach Aches	O Chicken Pox
O Frequent Colds	O Constipation	O Convulsions	O Influenza/flu
O Headaches	O Anemia	O Blood Disorders	O Measles
O Asthma	O Rheumatic Fever	O Scoliosis	O Other _____

PAST HEALTH HISTORY

Location of Birth: O Home O Birthing Center O Hospital O Stepchild O Adopted

Complication during pregnancy/delivery? Y N _____

Birth intervention: O Forceps O Vacuum O Caesarian, Why? _____

Is your child under medical care for any condition? Y N _____

Is your child on any medication? (List ALL) Y N _____

Has your child had surgery? (List ALL) Y N _____

Has your child had any broken bones? (List ALL) Y N _____

Has your child been in automobile accident? (List Injuries) Y N _____

Has your child had any major illness, injuries or falls? Y N _____

Kinsella Chiropractic Clinic

407 South Sibley Avenue Litchfield, MN 55355
(320) 593-4494 Fax: (320) 593-4495

Childhood Disease

O Chicken Pox- Age ___ O Mumps- Age ___ O Rubella- Age ___ O Whooping Cough- Age ___
O Measles- Age ___ O Meningitis- Age ___ O Tuberculosis- Age ___ O Other- Age _____

Immunization Records
Write the DATE immediately afterward.

O HBV/Hep B (Hepatitis B) - _____ O MMR (Measles, Mumps, Rubella) -_____
O DTP or O DTaP (Diphtheria, Tetanus, Pertussis) - _____ O Varicella- _____
O HbCV/Hib (H. influenza type b conjugate) - _____ O PCV (Pneumococcal) - _____
O OPV (Oral Polio Vaccine) - _____ O IPV (Inactivated Poliovirus) - _____
Adverse Reactions to any Vaccine? Y N List: _____

CONSENT TO CHIROPRACTIC CARE OF A MINOR: I certify that the information that I have supplied is correct and accurate to the best of my knowledge. I, _____, being the parent or legal guardian of _____ hereby grant permission for my child to receive chiropractic care.

Signature: _____ Date: _____

AUTHORIZATION TO RELEASE INFORMATION: I hereby confirm that all the information provided by me is accurate. Any false information will result in my responsibility for any costs incurred due to fraudulent information. I authorize release of any medical or other information necessary to process my insurance claim.

Signature: _____ Date: _____

AUTHORIZATION OF PAYMENT: I realize that any insurance that I have is a contract between myself and that company. I authorize all insurance benefits to the Physician for services performed. I am responsible for providing the insurance information for the submission of claims. I am also responsible for any non-covered services or for services for which no referral was obtained.

Signature: _____ Date: _____

ACKNOWLEDGEMENT OF PRIVACY PRACTICES: I have had the opportunity to obtain a copy of Notice of Privacy Practices for Protected Health Information (HIPAA). I have been informed that I may have a copy of this notice at any time. I have been informed that the Medical Practice has available to me a copy of the Notice of Privacy Practice for Protected Health Information posted in the waiting room for my use.

Signature: _____ Date: _____

Doctor's Signature: _____ Date: _____

We want to **THANK YOU** for taking the time to thoroughly complete these forms. Our goal is to give you the highest form of care possible.

Dr. Timothy R. Kinsella, D.C
And Staff