



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

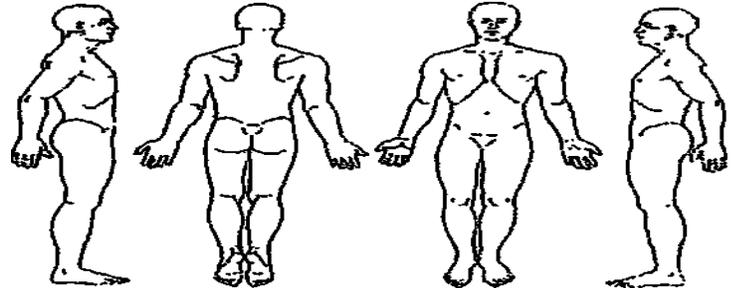
Pediatric Form (0-3yrs) 1/2

Patient First Name: _____ Middle Name: _____ Last Name: _____
 Name of Parent/Guardian: _____ DOB _____ Sex: M F
 Address: _____ City: _____ State: _____ Zip Code: _____
 Home Phone: _____ Social Security #: _____ Birth Weight: _____ Height: _____
 Payment Choice: Medicare Minnesota Assistance Work Comp Auto Cash Insurance Name: _____

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CHIEF COMPLAINT

Mark discomfort

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: _____

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

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

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PAST HEALTH HISTORY

Location of Birth: Home Birthing Center Hospital Stepchild Adopted
 Complication during pregnancy/delivery? Y N _____
 Birth intervention: Forceps Vacuum 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 _____

Doctor's Signature _____ **Date** _____



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 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.

By providing your signature below, you consent to text and email communications regarding upcoming appointments and promotions. Your information will never be shared with any third party. You can op-out at any time or by initializing here _____.

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.