KIDSPACE Adaptive Play and Wellness
469 Buckland Road, Suite 102
South Windsor, CT 06074

CHILDREN AGES 5 through 13 YEARS OLD
Intake Questionnaire

Today's Date: _____ /_____ /_____

Name: _____

Date of Birth: _____ /_____ /_____ Age: _____ Gender: _____

Street Address:_____

City:_____ State:_____ Zip Code:_____

Family Status: _____

Parent/Guardian 1: _____

Preferred Phone: (_____)_____-_____ Occupation:_____

Email Address: _____

Parent/Guardian 2: _____

Preferred Phone: (_____)_____-_____Occupation:_____

Email Address: _____

With whom and how should we be in touch regarding your child's care?

Parent/Guardian_____Text/Call/Email_____

Whom may we thank for referring you to KIDSPACE: _____

MEDICAL PROVIDERS and CONSENT TO SHARE RECORDS

List the names of your medical providers. Check the appropriate box to indicate whether or not you would like us to share records.

Pediatrician_____ ☐ **Yes** ☐ **No**

Dentist_____ ☐ **Yes** ☐ **No**

Other_____ ☐ **Yes** ☐ **No**

Parent/Guardian 1 Signature: _____

Parent/Guardian 2 Signature: _____

CURRENT CONCERNS

Please list your concerns about your child in order of importance:

1. _____
2. _____
3. _____
4. _____

What are his/her current symptoms: _____

When did they begin? _____

How did they begin? _____

Has he/she had any treatment for these symptoms? _____

What are you goals for your child's care at KIDSPACE?

_____

Describe your child in your own words:

_____

PREGNANCY and LABOR

Mom's age when baby was born?_____How many pregnancies? _____Live births? _____

Any problems conceiving?_____Treatment?_____

How was pregnancy overall?_____

During pregnancy was mom on medication (over the counter/prescribed/recreational)?

_____

During pregnancy did mom smoke or consume any alcoholic beverages? _____

Was mom in pain during pregnancy?_____

Was mom physically ill? (colds, flu, allergies, German measles, etc.)_____

Was labor chemically induced?_____Doctor assisted?_____

Approximately how long was labor?_____Who was present?_____

C-section?_____Were forceps/vacuum used?_____

Did doctor have hands on the child?_____What position was mom in?_____

Any time in NICU?_____Why?_____How long?_____

What was baby's gestational age?_____Length?_____Weight?_____Head circumference?_____

Baby's APGARS:_____1 min_____5 min; Any problems at birth?_____

Did mom breastfeed?_____Any problems?_____How long?_____

Did mom bottlefeed?_____What formula?_____Any problems?_____

Did mom see a lactation consultant in hospital?_____Who?_____

Did mom see a lactation consultant privately?_____Who?_____

MEDICAL HISTORY

Please describe any major illnesses, previous diagnoses, hospitalizations, surgeries, major accidents/injuries, x-rays, CAT scans, MRIs, EKGs, etc. :

Date	Description

Please list any known allergies (drugs, food, environmental, chemical, etc) and the reactions to them:

_____

Please list any and all current medications (prescription and over-the counter) & supplements including (vitamins, herbs, homeopathic remedies):

Name of Drug/Supplement	Date Started	Dosage/Frequency	Prescribed for:

Does your child have any of the following?

_____Allergies	_____Asthma	_____Bedwetting
_____Bloody Noses	_____Frequent Colds	_____Constipation
_____Congestion	_____Diarrhea	_____Digestive Problems
_____Ear Problems	_____Fatigue	_____Flu
_____Headaches	_____Hyperactivity	_____Irritability
_____Learning Disorders	_____Milk/Lactose Intolerance	_____Meningitis
_____Menses	_____ Nervousness	_____Poor posture
_____Rashes	_____Sleeping Disorders	_____Snoring/Apnea

Other_____

Please describe your child's habits as good, fair or poor:

Bowel_____ Eating_____ Listening_____

Mood_____ Sleeping_____ Physical Strength_____

Has your child had any of the following illnesses?

_____Measles	_____German Measles	_____Mumps
_____Pneumonia	_____Scarlet Fever	_____Chicken Pox
_____Cancer	_____Rheumatic Fever	_____Urinary Tract Infection
_____RSV	_____Rotavirus	_____Strep Throat
_____HIV/AIDS	_____Tuberculosis	_____Other Illnesses

Has your child had any extensive dental work, extractions or orthodonture?

_____

Does your child have difficulty with food textures, chewing, or swallowing solids or liquids?

_____

DEVELOPMENTAL INFORMATION

Please indicate which important milestones your child has attained. If he/she was late please indicate.

- Sitting up_____
- Crawling_____
- Walking_____
- Talking_____
- Skipping_____
- Standing on one foot_____
- Catching a ball_____
- Socializing_____

Is there anything you would like to tell us about your child's development thus far?

_____

SCHOOL AND SOCIAL HISTORY

Is your child home-schooled or enrolled in a traditional public, private, or special school?

_____

Does your child experience stress from school work load?_____

- Academic performance?_____
- Peers?_____
- Athletic performance_____
- Other interests?_____

Does your child have sensory sensitivities?

_____

Difficulties with Coordination?

_____

IMMUNIZATION RECORD

Please record the date of each immunization given to your child.

Vaccine	Date Given (m/d/yy)	Vaccine	Date Given (m/d/yy)
Hepatitis B		**Hepatitis A**	
Diptheria, Tetanus, Pertussis		**Meningococcal**	
		Human papillomavirus	
		Zoster (shingles)	
boosters			
		Influenza (yearly)	
***Haemophilus influenzae* type b**			
Pneumococcal			
		Other	
Polio			
Rotavirus			
Measles, Mumps, & Rubella			
Varicella (chickenpox)			

Is your child up to date on all immunizations? ☐ Yes ☐ No

Please list any adverse reactions to immunizations. Please be specific.

_____

_____

_____

Were these reactions reported to VAERS? ☐ Yes ☐ No

FAMILY MEDICAL HISTORY Please specify maternal vs paternal grandparents.

	Mother	Father	Brothers	Sisters	Maternal/Paternal Grandparents
Check if applicable					
Cancer					
Diabetes					
Heart Disease					
High Blood Pressure					
Stroke					
Epilepsy					
Mental Illness					
Asthma					
Kidney Disease					
Autoimmune Disease					
Other					

CONSENT FOR TREATMENT OF A MINOR

We, the parents or guardians, consent to the treatment/procedure rendered to our child or ward under general and specific instructions of my child's health care provider including but not limited to chiropractic, CranioSacral therapy, massage, sensory processing, or recreational therapy, as well as nutritional, homeopathic and herbal therapies and whole health counseling. We have had the mechanisms and risks of chiropractic adjustments based on pediatric anatomy and physiology explained to our satisfaction and authorize said treatment on the above-named child understanding the risks and incidence of deleterious effect. We recognize that even the gentlest therapies may potentially have complications in very young children, or in those on multiple medications. Hence, the information we have provided our health care providers is complete and inclusive of all health concerns and medications, including over-the-counter medications, supplements, and herbs our child may be taking. With this knowledge, we voluntarily consent to the proposed procedures. We acknowledge that no guarantees of cure or improvement of condition have been made. We understand that we are free to withdraw consent and to discontinue treatment at any time. We attest that we are the legal parent(s)/guardian(s) and are designated and authorized to make healthcare decisions and consent to healthcare for this child.

Our practice is collaborative in nature. We often consult with each other and co-manage in order to best serve our patients.

You are responsible for informing our providers of any relevant information or changes that affect your child's health. Should privileged information be shared via text message or email, your provider will make every effort to maintain privacy but text messaging and emailing are not encrypted or HIPAA-approved means of communication.

_____

Parent/Guardian Signature 1 Date

_____

Parent/Guardian Signature 2 Date

CONSENT TO PHOTOGRAPH

Photographs of your child help us see changes and help us teach other health care providers about caring for children with similar problems. Due to HIPAA regulations, we will ask permission from you to photograph your child and would like you to check beside each item that you consent to use your child's photo for:

Recording progress in the child's chart: ☐ Yes ☐ No _____ _____ Parent/Guardian Initials

For use in a professional presentation: ☐ Yes ☐ No _____ _____ Parent/Guardian Initials

For use in a professional publication: ☐ Yes ☐ No _____ _____ Parent/Guardian Initials

PARENT RESPONSIBILITIES
We agree to be financially responsible for all charges incurred at this office. We will make payment as required at the time of service. Should collection efforts be necessary to collect money owed, ***a 15% interest charge will be added to the balance due.*** We are liable for any cost incurred by the office in collection efforts.

CANCELLATION POLICY
If you are unable to make your appointment, please provide at least 24-hour notice of cancellation. ***A cancellation fee of $50 will apply for appointments cancelled with less than 24-hour notice.***

_____

Signature Date

Our office requires a credit card to be kept on file for any charges incurred.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES
This document is to be signed by persons legally responsible for the patient's medical decisions relative to the treatment situation.
We, _____, hereby acknowledge that we have been provided with a copy of the Notice of Privacy Practices that describes how medical information about our child/guardian may be used and disclosed, and how we can access that information. We understand that if we have questions or complaints, I may contact: **Faraneh Carnegie-Hargreaves, DC, Karen Peck CTRS, CST, QST**; or **Sharon A. Vallone, DC, FICCP at 860.432.9923.**

We also understand that we are entitled to receive updates upon request if this office amends or changes its Notice of Privacy Procedures in a material way.

_____

Parent/Guardian 1 Signature Date

_____

Parent/Guardian 2 Signature Date

This section is to be completed by our office, if unable to obtain written acknowledgement from patient.
I made a good faith effort to obtain written acknowledgement of receipt of the Notice of Privacy Practices from the above-named patient, but was unable because:
[ ] Patient declined to sign this written acknowledgement.
[ ] Other (specify):_____

_____

Name and title of employee Date