SYCAMORE INTEGRATED HEALTH
Infant/Child Patient Intake Form

PATIENT INFORMATION

Name_____ Date_____ Email*_____

Email will not be shared and will only be used for occasional office announcements and appointment reminders

Address_____ City_____ State_____ Zip_____

Cell Phone_____ Home Phone_____ Work Phone_____

Sex □ M □ F Birth Date_____ Age_____ Social Security Number_____

□ Single □ Married □ Widowed □ Separated □ Divorced Number of Children_____

Emergency Contact_____ Phone _____

How did you hear about this clinic?_____ Name of person who referred you_____

Race: American Indian / Alaska Native / Asian / Black or African American / White (Caucasian)
Hawaiian or Pacific Islander / I decline to answer

Ethnicity: Hispanic or Latino / Non-Hispanic or Latino / I decline to answer

**** CMS requires providers to report both race and ethnicity**

PARENT/GUARDIAN INFORMATION

Name: _____ _____ _____
LAST FIRST MI

Address: _____ _____ _____
STREET CITY STATE, ZIP

SS#: _____ Relationship: _____ DOB: _____

Employer: _____ Work Phone: _____

ADDITIONAL TREATMENT INFORMATION

Nature of the Injury: □ Automobile □ Work □ Other

Reason for seeking chiropractic care:_____

Any other health coniditions of concern: _____

Prior treatment and outcome: _____

Number of doses of antibiotics your child has taken:
a.) In the last six months: _____
b.) Total during his/her life: _____

Number of doses of other prescription medications your child has taken:
c.) In the last six months: _____
d.) Total during his/her life: _____

Parent/Guardian Signature_____ Doctor Signature _____

DETAILED HISTORY

Feeding History

	Yes	No	?	Details & Comments
Breastfed?	❑	❑	❑	How long?
Formula?	❑	❑	❑	How long?
Introduced to solids at how many months?	❑	❑	❑	
Introduced to cow's milk at how many months?	❑	❑	❑	

Prenatal History

Complications during pregnancy?	❑	❑	❑	Describe:
Ultrasounds during pregnancy?	❑	❑	❑	How many:
Medications during pregnancy/delivery?	❑	❑	❑	Please list:
Cigarette/alcohol use during pregnancy?	❑	❑	❑	
Location of birth				Hospital ❑ Home ❑ Other ❑
Birth interventions				Forceps ❑ Vacuum extraction ❑ C-Section ❑
Delivery complications?	❑	❑	❑	Describe:
Birth stats				Weight Length APGAR score

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

(**C**=Child – **F**= Family Member)

C	F		C	F		C	F		C	F	
❑	❑	ADHD	❑	❑	Convulsions	❑	❑	Hypertension	❑	❑	Rashes
❑	❑	Allergies	❑	❑	Cough/Wheeze	❑	❑	Insomnia	❑	❑	Rheumatic Fever
❑	❑	Anemia	❑	❑	Diabetes	❑	❑	Itchy Eyes	❑	❑	Runny Nose
❑	❑	Arm/Elbow Pain	❑	❑	Diarrhea	❑	❑	Joint Pain	❑	❑	Scoliosis
❑	❑	Arthritis	❑	❑	Digestive	❑	❑	Knee/Foot Pain	❑	❑	Sinus Trouble
❑	❑	Asthma	❑	❑	Dizziness	❑	❑	Leg/Hip Pain	❑	❑	Sprains/Strains
❑	❑	Backaches	❑	❑	Fainting	❑	❑	Muscle Pain	❑	❑	Stomach Aches
❑	❑	Bed Wetting	❑	❑	Fever/Chills	❑	❑	Neck Pain	❑	❑	Tuberculosis
❑	❑	Behavioral	❑	❑	Frequent Colds	❑	❑	Neuritis	❑	❑	Unusual Moles
❑	❑	Blood disorders	❑	❑	Growing pains	❑	❑	Nightmares	❑	❑	Other
❑	❑	Broken bones	❑	❑	Headaches	❑	❑	Pain Urinating	❑	❑	_____
❑	❑	Chest Pain	❑	❑	Heart Condition	❑	❑	Paralysis	❑	❑	_____
❑	❑	Chronic Earaches	❑	❑	Hernias	❑	❑	Poor Appetite	❑	❑	_____
❑	❑	Constipation	❑	❑	Hyperactivity	❑	❑	Poor Memory	❑	❑	_____

Parent/Guardian Signature_____ Doctor Signature _____

Family Health History:

Have the child's parents, siblings, or grandparents ever experienced and of the problems listed on the previous page? ❑ Yes ❑ No if yes please list _____

Name of Pediatrician: _____ Date of last visit _____

Reason for visit: _____

Medications and conditions being treated: _____

Has your child ever taken antibiotics? Y/N Condition treated:_____

Has your child been injured participating in contact sports (Soccer, Football, Martial Arts…) Y/N If yes, describe (Sprain, Broken Bone, Head Trauma…)

_____

Has your child ever been involved in a car accident? Y/N Date & Injuries

_____

Has your child ever fallen head first from (Changing Table, Bed, Stairs…) Y/N

_____

Other traumas not described above? Y/N Type & Date: _____

_____

Prior surgery: Y/N Type and Date:_____

Menarche: Y/N Age:_____

Childhood Diseases

	Disease	Age		Disease	Age
❑	Chicken Pox	_____	❑	Measles	_____
❑	Mumps	_____	❑	Meningitis	_____
❑	Rubella	_____	❑	Tuberculosis	_____
❑	Whooping Cough	_____	❑	Other	_____

Vaccination History:

- ❑ HBV / Hep B (Hepatitis B)
- ❑ DTP
- ❑ HbCV / Hib (H. influenzae type b conjugate)
- ❑ OPV (Oral Polio Vaccine)
- ❑ MMR (Measles, Mumps, Rubella)
- ❑ DTaP (Diphtheria, Tetanus, Pertussis)
- ❑ Varicella (Chicken Pox)
- ❑ PCV (Pneumoccocal)
- ❑ IPV (Inactivated Poliovirus)
- ❑ My child is not vaccinated

Adverse Reactions to Any Vaccine? Y/N List: _____

Parent/Guardian Signature_____ Doctor Signature _____

Assignment of Benefits

My signature and date in the box below authorizes each of the following:

1. Assignment of Medicare, Medicaid, Medicare Supplemental or other insurance benefits to Sycamore Integrated Health for medical supplies and/or medication(s) furnished to me by Dr. Zachary Sheedy, Dr. Morgan Sheedy, or Dr. William Baxter.

2. Direct billing to Medicare, Medicaid, Medicare Supplemental or other insurer(s).

3. Release of my medical information to Medicare, Medicaid, Medicare Supplemental or other insurers and their agents and assigns.

4. Dr. Zachary Sheedy, Dr. Morgan Sheedy, or Dr. William Baxter to obtain medical or other information necessary in order to process my claim(s), including determining eligibility and seeking reimbursement for medical supplies and/or medication(s) provided.

5. Dr. Zachary Sheedy, Dr. Morgan Sheedy, or Dr. William to contact me by telephone or mail regarding my medical supplies and/or medication(s) order.

I agree to pay all amounts that are not covered by my insurer(s) including applicable co-payments and/or deductibles for which I am responsible.

Your Phone Number: _____

Signature_____ Date_____

I request that payment of Medicare, Medicaid, Medicare Supplemental or other insurance benefits be made on my behalf to Dr. Zachary Sheedy, Dr. Morgan Sheedy, or Dr. William Baxter for any medical supplies and/or medications furnished to me by any one of the aforementioned. I authorize any holder of medical information about me to release to Dr. Zachary Sheedy, Dr. Morgan Sheedy, or Dr. William Baxter, my physician(s), caregiver, CMS, its agents and to my primary and/or other medical insurer any information needed to determine or secure eligibility information and/or reimbursement for covered services. I agree to pay all amounts that are not covered by my insurer(s) and for which I am responsible.

Medicare Number: ☐☐☐-☐☐-☐☐☐☐-☐

Insurer (other than, or in addition to Medicare) _____

Policy number: _____

Insurer Phone number: _____

Terms of Acceptance

Open Floor Environment
Sycamore Integrated Health utilizes an "open treatment area" in which several people may be treated at the same time and in close proximity, and any exercises and therapies will be done in a group setting in this open environment. Complete privacy may not be possible in this setting, therefore if you would prefer to be seen in a private room or have a question or concern that you wish to be addressed in private, it is your responsibility to let us know and we will do our best to accommodate your wishes.

Children in the Office
Children are always welcome in the office; however their safety and wellbeing are not the responsibility of the doctors or staff. By bringing children into the office you understand and agree to the fact that they are solely your own responsibility and must be kept off the treatment floor and under complete control at all times.

Ownership of X-ray Films:
It is understood and agreed that the payments to the Doctor for X-rays is for examination of X-rays only. The X-ray negative will remain the property of the office. They are kept on file where they may be seen at any time while I am a patient at this office.

Patient Rights and Responsibilities:
I have read the Patient Rights and Responsibilities (found in the welcome packet) and I understand my rights as a patient and I agree to uphold my responsibilities.

I hereby authorize the staff to perform such services as deemed necessary by the physician to diagnose and treat my condition(s). Further, I authorize assignment of my insurance rights and benefits directly to this provider and also authorize the release of such information as is needed to process insurance claims. I understand that I am responsible for all charges which may include legal fees, collection fees, or other expenses incurred by the provider in collection my account. I hereby order all parties to accept a copy of this release and assignment in lieu of the original. This shall remain in effect until revoked by me in writing.

By my signature below I acknowledge that any questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction and I have a full understanding of the office policies and practices. I therefore accept chiropractic care on this basis.

Patient's Signature _____ Date_____

HIPAA Consent for Purposes of Treatment, Payment & Healthcare Operations

In this document, "I" and "my" refer to the patient, And the "Clinic" refers to Sycamore Integrated Health

I consent to the use or disclosure of my protected health information by the Clinic for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of the Clinic. I understand that analysis, diagnosis or treatment of me by the Clinic may be conditioned upon my consent as evidenced by my signature below.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. The Clinic is not required to agree to the restrictions that I may request. However, if the Clinic agrees to a restriction that I request, the restriction is binding on the Clinic.

I have the right to revoke this consent, in writing, at any time, except to the extent that Clinic has taken action in reliance on this Consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I have been provided with a copy of the Notice of Privacy Practices of the Clinic and understand that I have a right that Notice 's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the Clinic. The Notice of Privacy Practices for Clinic is also available at the front desk at 920 W. Prairie Dr., Suite J, Sycamore, IL 60178. This Notice of Privacy Practices also describes my rights and duties of the Clinic with respect to my protected health information.

The Clinic reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the Clinic and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____ _____
Signature of Patient or Personal Representative Printed Name of Patient

_____ _____
Date of Signing Description of Personal Representative's Authority

_____
Witness Signature

□ I choose to decline receipt of my clinical summary after every visit (these summaries are often blank as a result of the nature and frequency of care)

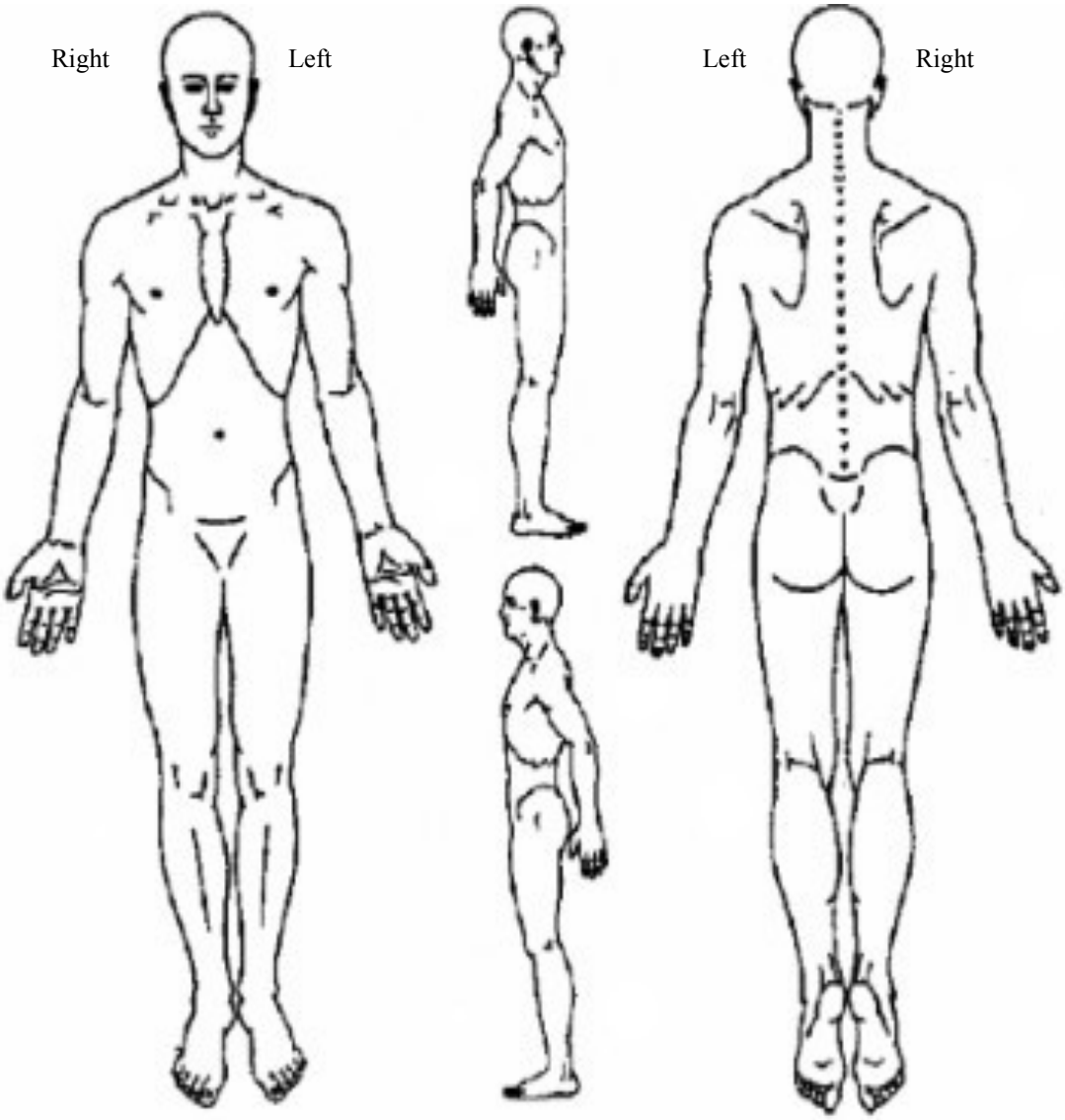
Pain Diagram

Name_____ Date_____

Patient Signature: _____

Please indicate by **circling the location of your pain and discomfort on the diagram below. Use the letters noted below to describe each area of pain that has been circled.

D: Dull
B: Burning
N: Numb
S: Stabbing/cutting
T: Tingling (pins and needles)
C: Cramping/spasm

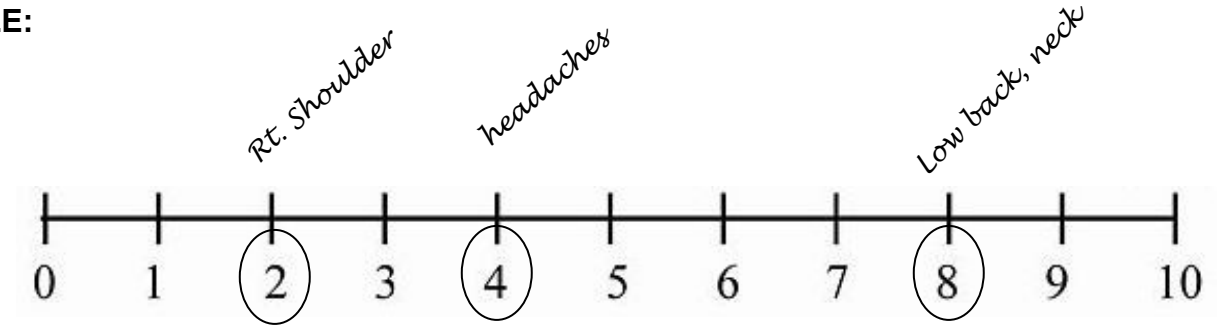


Pain Scale

Name_____ Date_____

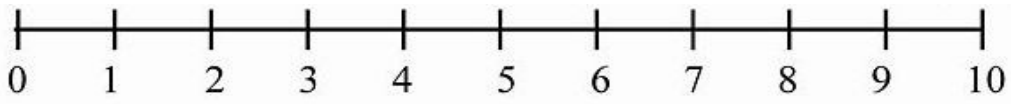
Please use the scales below to mark your pain levels for **EACH** region you experience pain (see example). Please indicate your pain levels using the last 3 months as your reference. If you have completed this form before, indicate your average pain levels since the last time you completed this form.

EXAMPLE:

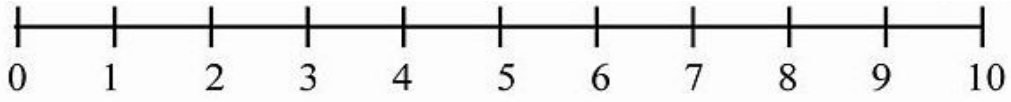


No pain	**Mild** Pain can be ignored	**Moderate** Interferes with tasks	**Moderate** Interferes with concentration	**Severe** Interferes with basic needs	**Worst Pain Possible** Bed rest required

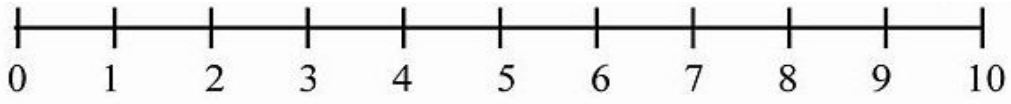
1. What is your pain RIGHT NOW?



2. What is your TYPICAL or AVERAGE pain?

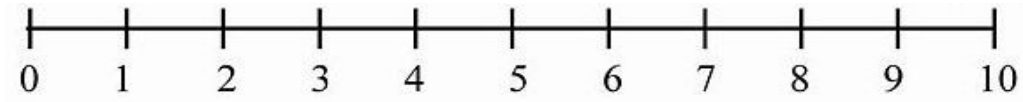


3. What is your pain at its BEST (how close to "0" does your pain get at its best)?



What percentage of your awake hours is your pain at its best? _____%

4. What is your pain at its WORST (how close to "10" is your pain at its worst)?



What percentage of your awake hours is your pain at its worst? _____%

OFFICE USE ONLY

Score: #1_____ + #2_____ + #4 _____ /3 x100 = _____

<50= low intensity >50= high intensity