Functional Medicine Pediatric Intake Form

Today's Date: _____

Last Name: _____ First Name: _____ MI: _____

Parent(s): Mother_____Father_____ Birthdate: _____/_____/_____ Sex: M / F

Mailing Address: _____ City: _____

State: _____ Zip Code: _____ Home Phone: _____

Emergency Contact: _____Relationship to Patient: _____

Contact's Phone Number: _____ Contact's Email: _____

Referred to Abundant Life Family Chiropractic by: _____

Current Health Care Team:

Patient's Pediatrician: _____ Office Number: _____

Specialist Physician: _____ Specialty: _____ Office Number: _____

Specialist Physician: _____ Specialty: _____ Office Number: _____

Other Health Care Team Members (Ex: massage therapist, nutritionist, acupuncturist, etc.):

Practitioner Name: _____ Office Number: _____

Practitioner Name: _____ Office Number: _____

Please list current health concerns, time of onset, and current treatment:

Condition		*Onset/Duration*	*Treatment (if any)*
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

PAST MEDICAL HISTORY

Pregnancy:

Duration of pregnancy:_____

Any complications with pregnancy? _____

Type of birth delivery: cesarean section / vaginal Birth Weight:____ lb. Height ____ in.

Any complications with delivery? _____

Newborn:

Any significant health concerns as newborn? (eg. anemia, jaundice, respiratory difficulty, infection)

_____

To date, please list history of all major illnesses, hospitalizations, surgical procedures including dates.

_____

History of head injury or other major injury? _____

Has this child ever been unconscious or had seizures? _____

Immunizations/vaccinations:

_____

_____

Date of last Physical/Wellness Exam: _____ Date of last Blood Tests:_____

Please list any Life Threatening Allergies: _____

Other Allergies, sensitivities, or intolerances (eg. food, medication, environmental, chemical, etc.):

_____

FAMILY HISTORY:

Place appropriate letter(s) in blank if someone in the child's family has/had any of the following.
(F=Father, M=Mother, S=Sibling, G=Grandparent)

___ Alcoholism
___ Allergies/Eczema
___ Asthma
___ Autoimmune Disorders
___ Cancer, specify type(s):
_____
___ Crohn's Disease
___ Diabetes
___ Drug abuse
___ Epilepsy/Seizures
___ Headaches/Migraines
___ Heart Disease
___ Neurological Disorders
___ Obesity
___ Sexually Transmitted Infections: _____
___ Thyroid Disorder

Any other condition:_____

LIFESTYLE:
Please select the following that apply to this child (write N/A if does not apply)

___ Stays at home ___ Involved in after-school activities (Ex: _____)

___ Daycare (___ days/week) ___ Socializes well with other children

___ School (grade level_____) ___ Holds attention while working on a task

Describe the child's family situation: (number of siblings, parental involvement in child's life, etc):

_____

_____

Favorite Activities: _____

Fears and Anxieties: _____

DIET:

Please check any of following: ___Mixed Diet (animal/vegetable) ___Vegetarian ___ Organic

Please list any Food Restrictions (eg. dairy, gluten, soy, etc.): _____

_____

I have completed this form to the best of my ability in reference to this child's health history. I have stated all known health conditions for this child and will alert the physician of any new condition as it arises. I agree to take full responsibility for bringing this child to chiropractic and/or functional medicine care.

Signature: _____ Date: _____

Relationship to Patient: _____

Please list any vitamins, minerals, herbal supplements, homeopathics, over-the-counter and prescribed medications and creams that you are taking.

NAME: _____ DATE: _____

SUPPLEMENT	MANUFACTURER	FORM	DOSAGE	FREQUENCY
EXAMPLE: VITAMIN C	PERQUE	powder	1500 mg= ! tsp	! tsp 2 times/day

MEDICATION	FORM	DOSAGE	FREQUENCY	DATE STARTED

Describe any history of drug reaction/allergy: _____

_____

OTHER COMMENTS:

Informed Consent for Consultation and Treatment

I, _____ , hereby authorize the practitioners at Abundant Life Family Chiropractic to perform the following specific procedures and services as necessary to facilitate in The treatment of myself or my minor child:

Physical exam: e.g., general, musculoskeletal, cardiovascular, abdominal, respiratory
Medicinal use of nutrition: therapeutic nutrition, nutritional supplementation.
Botanical medicine: botanical substances may be prescribed as teas, alcoholic tinctures, capsules, tablets, creams, plasters, solid extracts, or suppositories.
Hormone therapies: natural, bio-identical hormone therapies
Homeopathic medicine: the use of highly dilute quantities of naturally occurring plant, animal, and mineral substances to gently stimulate the body's healing responses.
Lifestyle and nutritional counseling and hygiene: diet therapy, recommendations for exercise, sleep, stress reduction, and balancing of work and social activities, mind-body supportive counseling
Acupuncture and Chinese Medicinal Herbs
Holistic Transformational Coaching
Contraception
Physical Medicine: e.g., Chiropractic, Colon Hydrotherapy, Craniosacral therapy, Visceral Manipulation
Venipuncture: blood draw to be submitted for tests ordered

All practitioners at Abundant Life Family Chiropractic are certified or licensed as require by their jurisdiction.

I understand that the Dr. Wehling at Abundant Life is a licensed, board-certified chiropractic physician in the state of Nebraska, based upon a four-year graduate training in an accredited university as a chiropractic physician.

The chiropractic physician will explain to me his assessment, the nature of his recommendations, the expected prognosis without such care, and the anticipated costs, risks, benefits and experience of following various options. I understand that the focus of functional med. care is to alleviate the underlying conditions that can bring about illness rather than the treatment of symptoms. While I may experience some immediate improvement from the use of naturopathic methods, I understand that the most effective results occur when I make a long-term commitment to rebuild my health. It is my responsibility as a patient to follow-up with the chiropractic physicians within a recommended time period for evaluation of treatment results or to change treatment protocols as necessary.

I understand that Dr. Wehling does not offer after hour services or provide any hospital-based services. If I have difficulty with any of the remedies or other aspects of my work with the doctors, I understand I should call during business hours to discuss concerns I may have.

Potential risks: As with any method of care, there may be risks, such as allergic reactions to prescribed herbs and supplements, side effects of natural medications, inconvenience of lifestyle changes or injury from procedures. I understand that it is my responsibility to alert the practitioner(s) of any adverse effects or reactions.

Notice to Pregnant Women: All female patients must alert the practitioner(s) at Abundant Life Family Chiropractic if they know or suspect that they are pregnant as some of the therapies used could present a risk to the pregnancy.

Important Insurance and Payment Notices: Abundant Life Family Chiropractic does not bill insurance companies but will supply you with all insurance codes necessary to submit your claims for reimbursement at the time of your visit. Our doctors are not preferred providers for any insurance company, but many companies cover our visit fees as "out of network" physicians. Medicare will not reimburse you for Functional Medicine services rendered at ALFC. Payment in full is required at each visit. I understand I am responsible for payment even if I submit and am denied reimbursement, even if my insurer determines that services are not medically necessary. I understand that functional med visits by phone are more likely denied reimbursement compared to in-office visits. Both Flex Spending Plans and Health Savings Accounts can often be used to cover any visit fees not covered by your insurance. In addition, they will usually cover any laboratory fees not otherwise covered and most nutritional or herbal supplements prescribed.

Cancellation and Rescheduling of Appointments Policy: Our practitioners request 24-hours notice for canceling or rescheduling appointments. For any visits cancelled with less than 24-hours notice, the patient may be charged the full amount of the original visit fee except in the case of family or medical emergency. This charge will be billed directly to the client. Late arrivals will not receive an extension of scheduled service times and will be responsible for full service fee. In the event legal action is required to collect payment, I agree to be responsible for attorney fees and costs.

With this knowledge, I voluntarily consent to the above procedures, realizing that the doctors at ALFC or any personnel have given no guarantees to me by regarding cure or improvement of my condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time. I understand that it is not being recommended to me to discontinue any other treatment or care being provided by any other health care professional. I understand that this care not replace the service of my primary care physician. When appropriate, our doctors may communicate with members of my health team regarding my conditions, treatment options, and/or any other health related issues. I agree to follow-up on referrals for medical care when necessary.

I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by myself or my representative or unless required by law. I understand that my medical record will be kept for a minimum of three, but no more than ten years after the date of my last visit. I understand that full disclosure of information has been made to me and all my questions have been answered to my full satisfaction.

I have read and understand the above statements.

Patient Name _____ Signature _____

Legal Guardian Name (if needed) _____Signature _____

Date _____

FEES & POLICIES

Appointments:

Appointments are available Monday – Friday between 9 am and 6 pm. The office is closed from 1-2 pm daily and on the weekends.

Cancellation and Rescheduling of Appointments:

Our practitioners request 24-hours prior notice for canceling or rescheduling appointments. For any visits (in-office or telephone visits) cancelled with less than 24-hours notice, the patient will be charged the full amount of the scheduled visit fee.

Schedule of Fees for Services:

Fumctional Medicine Initial Visit, Adult (1.5 hour) – $200
Functional Medicine Initial Visit, Child (1 hour) – $150
Functional Medicine Return Visit (1 hour) – $100
Functional Medicine Return Visit (30 min) – $50

Nutritional Consultation Initial Visit (75 min) – $115
Nutritional Consultation Return Visit (45 min) – $75

Payment Policy:

Payment is due at the time of each visit. Visits are based on time spent with patient and the complexity of visit and are subject to change accordingly.

Insurance reimbursement:

ALFC does not bill insurance companies, but will supply you with all appropriate insurance codes necessary to submit your claims for reimbursement at the time of your visit. Our doctors are currently not preferred providers for any insurance company, but many companies cover our visit fees as “out of network” physicians, and the reimbursement will vary according to your specific contract. Medicare will not reimburse for services rendered by our doctors.

Flexible Spending Plans & Health Savings Accounts:

Both Flex Spending Plans and Health Savings Accounts can be used to pay for any visit fees not covered by your insurance. They will also usually cover laboratory tests and most nutritional and herbal supplements prescribed.