COWBOY SPINE
Performance Center

Gabriel W. Deal, D.C. M.S.
DrDeal@CowboySpine.com
CowboySpine.com
830-714-0006
830-714-0007

Pediatric Intake (0-5 years of age)

Patient information:

Date: _____

Child's Name: _____ DOB: _____

Parent/Guardian's name: _____

Home Phone #: _____ Cell Phone #: _____

Address: _____

E-mail Address: _____

Pediatrician/Phone #: _____

Prenatal History:

Mother's health status prior and during pregnancy: _____

_____

Maternal age for respective pregnancy: _____

How many pregnancies? _____ How many live births?_____

Approximate weight gain during pregnancy: _____

Complications during pregnancy? Preeclampsia? Eclampsia? _____

_____

Drug use during pregnancy (Rx, OTC, recreational, remedies): _____

_____

Presence of in utero constraint? (Breech position, etc.) _____

_____

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Natural History:

Place of birth: □ Home □ Birthing Center □ Hospital

Was your birth plan followed?: If not, give a brief description of what happened: _____

_____

_____

Provider: □ OBGYN □ Midwife □ Other: _____

Type of delivery: □ Vaginal □ Cesarean

Spontaneous or induced labor (Pitocin): _____

Epidural administered (yes/no): _____ Length of labor: _____

Instrument used: □ Vacuum Extraction □ Forceps □ None

Was an External Cephalic Version (ECV) performed? □ Yes □ No

Mother's birth position: □ On back □ Squatting □ Other: _____

Gestational age: □ Full term 37-42 weeks □ Premature <36 weeks □ Post term >42 weeks

Is there anything else you would like me to know about your pregnancy and labor/delivery?

_____

_____

History:

Did you breastfeed your child? □ Yes How long? _____ □ No □ Currently am

Has your child had any surgeries? □ Yes □ No

If yes, please list what kind of surgeries and how old they were:

_____

Has your child ever been on antibiotics? □ Yes □ No

If yes, how often and what for? _____

_____

Is your child currently taking any medications? □ Yes □ No

If yes, please list them: _____

_____

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Is your child currently taking any vitamins? □ Yes □ No

If yes, please list them: _____

_____

Is your child currently teething: □ Yes □ No

Has your child been vaccinated?: □ Yes □ No

Is your child currently experiencing any of the following?:

□ Colic □ Recurrent ear infections □ Incoordination while walking

□ Bedwetting □ Constipation □ Diarrhea

□ Sleep disturbances □ Difficulty crawling □ Learning difficulties/Hyperactivity

□ Asthma □ Allergies □ Other: _____

What brings your child to the office today?

_____

When did it start?

_____

Does anything make it better? □ Yes □ No If yes, please describe: _____

_____

How long does it last? □ All day □ Few hours □ Minutes

How frequent? □ Constant □ Intermittent □ Night only □ During certain activities

Describe the pain (if any):

□ Sharp □ Dull/achey □ Stabbing □ Shooting □ Tingling □ Other: _____

Does it travel anywhere?

_____

Are there any other symptoms that your child is currently experiencing that may or may not be related to the above condition? _____

_____

Doctor signature: _____ Date: _____

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CONSENT TO TREATMENT OF MINOR

Patient's name: _____

Parent/guardian: _____

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays, on me (or the patient named below, for whom I am legally responsible) by Dr. Olsen or Dr. Deal or other licensed doctors of chiropractic who now or in the future work at Cowboy Spine & Performance Center.

I've had an opportunity to discuss with the doctor of chiropractic named below and or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

Parent/Guardian Signature: _____ Date: _____

Employee Signature: _____ Date: _____

CANCELLATION/NO SHOW POLICIES:

Appointments

Please arrive on time for your appointments. The doctors try their best to stay on schedule and this needs your cooperation. If you happen to arrive late for an appointment, your visit may be shortened and end at the originally scheduled time in order to accommodate patients whose appointments follow yours.

Depending on the degree of your tardiness, your doctor will determine if there is enough time remaining to start your treatment.

Regardless of the length of time the treatment is provided, you will be responsible for the full amount of your scheduled appointment.

Tardiness in excess of 15 minutes will be considered a "No-Show" appointment and you may be asked to reschedule your current appointment.

Out of respect and consideration for your doctor and other patients, please plan accordingly and arrive on time for your appointments.

No-Show Policy

This policy is to ensure that patients have access to care when needed and to avoid the great expense to our office due to late cancellations and no shows. This policy is designed to help keep our costs down and keep appropriate care for all our patients. We take your time very seriously and are committed to serving you with the highest level of care. We ask that in return you respect our time as well.

Anyone who either forgets or consciously chooses to forgo a scheduled Chiropractic appointment will be considered a "No-Show." We reserve the right to charge you a **fee of $65** for your missed appointment. For anyone who forgets or consciously chooses to forgo a scheduled Massage appointment, we reserve the right to charge you up to the **FULL AMOUNT** of the scheduled Massage. The fee must be paid prior to scheduling your next appointment.

Cancellations

24 hour advanced notice is required when cancelling any appointment. This allows the opportunity for other patients to schedule an appointment. If you are unable to give us 24 hours advanced notice, we reserve the right to charge you a **fee of $65** for missed Chiropractic appointment, and the **FULL AMOUNT** for missed Massage appointment. This amount must be paid prior to your next scheduled appointment

I, _____, authorize Cowboy Spine & Performance Center to process payment on my Visa, MasterCard, Discover Card, or HSA card for the purposes of:

1.) My payment responsibilities as designated by our agreement by the end of the day on the date of service provided.
2.) Any outstanding balance that has not been received after 90 days of the service that was provided to me by a CSPC provider (i.e. chiropractic, massage, etc.).

I understand and agree that if an appointment is missed and I do not follow the cancellation policy as specified in the section Cancellation and Missed Appointment Policy, Cowboy Spine & Performance Center is authorized to charge my credit card up to the full cost of the missed appointment.

I understand and agree that if my card is declined, Cowboy Spine & Performance Center may put my credit card payment through on another day when funds become available.

I understand and agree that I have given Cowboy Spine & Performance Center my credit card information. I further understand that if I miss a scheduled appointment or fail to provide 24 hours notice, my credit card may be charged up to the full amount of the session.

I have read and understand this form. I attest that the information below is true and accurate.

_____

Signature of card holder

My credit card information is as follows:

_____	_____	_____
Cardholder's name	**Patient's name**	**Date**
_____	_____	_____
Credit Card Number	**Expiration Date**	**Security Code**
_____	_____	_____
Address Credit Card Account is under	**Zip Code CC Account is under**	**Email Address**

Medical Release of Information

☐ *I authorize the release of information including the diagnosis, records, examination rendered to my child and claims information. This information may be released to (not including legal guardians):*

- ☐ Family doctor _____
- ☐ Other _____

☐ Information is **not** to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by me or an authorized agent in writing.

Messages

Please call my ☐ cell, ☐ home, ☐ work number _____

If unable to reach me, *I authorize Cowboy Spine & Performance Center, PC or its employees to:*

- ☐ Leave a detailed message
- ☐ Leave a message asking for me to return your call
- ☐ _____

I understand and acknowledge that by my signing of this ***Release of Information*** *I will not hold Cowboy Spine & Performance Center, PC or its employees liable for any disclosure of my protected health information to the above entities or via message as described above.*

Signed: _____ Date: _____/_____/_____

Witness: _____ Date: _____/_____/_____