Pediatric Injury Intake
Suncoast SpineMED

First Name: _____ Middle Initial: _____ Last Name: _____

Parent Cell Phone #: _____ Parent Work Phone #: _____

Address: _____City: _____

State _____ Zip: _____ Parent E-mail Address: _____

SS#:_____-_____-_____ Age: _____ DOB: __ __ /__ __ /__ __ ☐ Male / ☐ Female

ACCIDENT INFORMATION: Date of Accident:_____ Where (Street/Intersection):_____

Were any tickets issued and to whom? _____

Where was the child seated: ☐ Front Seat Passenger (Right) ☐ Back Seat Left ☐ Back Seat Right ☐ Back Seat Middle

Did the impact to your vehicle come from the: ☐ Front ☐ Rear ☐ Left Side ☐ Right Side

Did the air bag deploy? ☐ Yes ☐ No Did child hit anything inside the vehicle? ☐ Yes ☐ No If yes, describe: _____

Did child experience immediate pain? ☐ Yes ☐ No Did the ambulance/paramedics arrive at the scene? ☐ Yes ☐ No

Was child taken to the hospital? ☐ Yes ☐ No Did child drive to the hospital? ☐ Yes ☐ No Which hospital? _____

Were x-rays taken? ☐ Yes ☐ No MRI? ☐ Yes ☐ No CT? ☐ Yes ☐ No Did they prescribe medication? ☐ Yes ☐ No

Is child taking new medication since the accident? ☐ Yes ☐ No Please List:_____

Please describe the accident in your own words: _____
_____

Has child seen any other healthcare provider since this accident? _____

Have you noticed changes in the child's behavior or mood since the accident? (more cranky, needy, poor sleep, acting out, etc)

No / Yes, please describe:_____

Date when symptoms first appeared: _____ Has child had this condition before? ☐ Yes ☐ No

What makes symptoms increase? _____ What relieves symptoms? _____

Has child complained of any pain since the accident? If so, please indicate where by checking the boxes below:

☐ Low Back Pain	☐ Tension Across Top of Shoulders	☐ Tired/Fatigued
☐ Pain between Shoulder Blades	☐ Numbness/Tingling in Arms/Hands	☐ Difficulty Sleeping
☐ Neck Pain	☐ Numbness/Tingling in Legs/Feet	☐ Ringing in Ears
☐ Difficulty talking	☐ Dizziness	☐ Brain Fog
☐ Tension/Headaches	☐ Pain in the legs/feet/buttocks	☐ Nausea
☐ Changes in Vision	☐ Pain in the hand/arm/shoulders	☐ Vomiting
☐ Difficulty swallowing	☐ Difficulty with balance	☐ Other: _____

PREVIOUS ACCIDENT HISTORY: Has child ever been involved in another motor vehicle accident? ☐ Yes ☐ No

If yes, please describe and give dates: _____

Application For Patient Care

PATIENT INFORMATION

Name of Parent\Guardian Accompanying Child Today: _____

Name of child's pediatrician: _____

Child's activities (sports, hobbies, video games, etc): _____

Child lives with: ☐ Mom & Dad ☐ Mom ☐ Dad ☐ Grandparents ☐ Other:_____

How many siblings does child have? _____ Sibling's Ages: _____

Emergency Contact Name:_____ Relation: _____ Phone #:_____

ACCIDENTS

Has child had an auto accident? (X if applies): ☐ 0-6mo ☐ 6 mo-1 yr ☐ 1-3yrs ☐ 3+yrs ☐ Never

Has child had a recent fall/other accident? (X if applies): ☐ 0 – 12 mo ☐ 1-3yrs ☐ 3+yrs ☐ Never

Has child ever received chiropractic care? ☐ Yes ☐ No Last Visit?_____

Has child ever received physical therapy? ☐ Yes ☐ No Last Visit?_____

Has child ever had an MRI? ☐ Yes ☐ No What Body Part?_____

INSURANCE

Is child covered by auto insurance? ☐ Yes ☐ No Name of Carrier: _____

Does child have health insurance? ☐ Yes ☐ No Name of Carrier: _____

Does child have secondary insurance? ☐ Yes ☐ No Name of Carrier: _____

PLEASE PROVIDE THIS OFFICE WITH A COPY OF YOUR INSURANCE CARD(S)

Assignment and Release (insured patients)

I certify that I (or my dependent) have insurance coverage with _____ and I AUTHORIZE, REQUEST AND ASSIGN MY INSURANCE COMPANY TO PAY DIRECTLY TO THE PHYSICIAN PRACTICE, Suncoast Physical Medicine, LLC, INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary, including the diagnosis and the records of any exam or treatment rendered to me, in order to secure the payment of benefits. I authorize the use of this signature on all insurance claims, including electronic submissions.

SIGNATURE (X) _____ **DATE** _____

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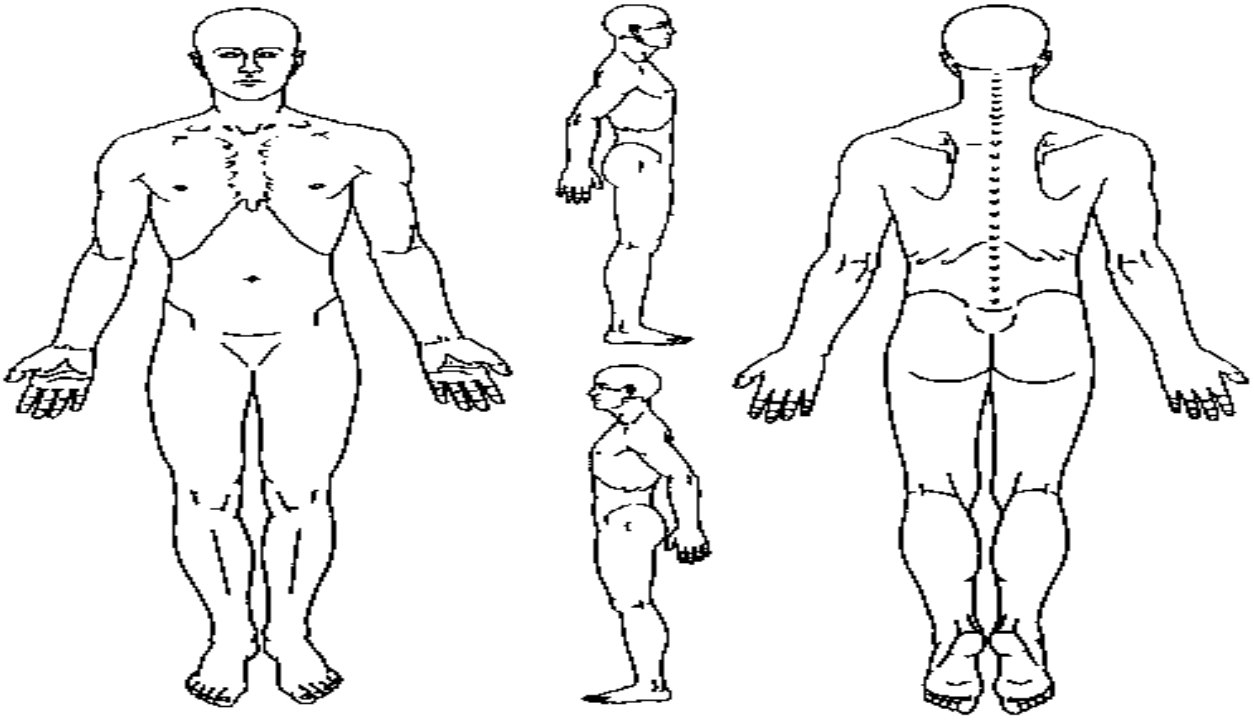
Please Mark Child's Areas of Pain



PAST MEDICAL HISTORY: Please check if child has ever had any of the following IN THE PAST:

❑ ADD/ADHD	❑ Cancer	❑ Heart Attack	❑ Mouth Sores or Bleeding Gums	❑ Sexual Difficulty
❑ Aids/HIV	❑ Cataracts	❑ Heart Problems	❑ Multiple Sclerosis	❑ Stroke
❑ Alcoholism	❑ Chemical Dependency	❑ Hemorrhoids	❑ Mumps	❑ Suicide Attempt
❑ Allergy Shots	❑ Chicken Pox	❑ Hepatitis	❑ Nosebleeds	❑ Thyroid Problems
❑ Anemia	❑ Colon Trouble	❑ Hernia	❑ Osteoporosis	❑ TMJ Pain
❑ Anorexia	❑ Contacts/Glasses	❑ Herniated Disc	❑ Pacemaker	❑ Tonsillitis
❑ Appendicitis	❑ Diabetes	❑ Herpes	❑ Parkinson's Disease	❑ Tremors
❑ Arthritis	❑ Dry Skin	❑ High Cholesterol	❑ Pinched Nerve	❑ Tuberculosis
❑ Asthma/Wheezing	❑ Ear Infections	❑ Hormone/Gland Problems	❑ Pneumonia	❑ Tumors/Growths
❑ Bad Breath/Bad Taste	❑ Epilepsy	❑ Insomnia	❑ Polio	❑ Typhoid Fever
❑ Bleeding Disorders	❑ Fractures	❑ Kidney Problems	❑ Prostate Problems	❑ Ulcers
❑ Blood Pressure: High or Low (circle)	❑ Gall Bladder	❑ Liver Disease	❑ Prosthesis	❑ Vaginal Infections
❑ Breast Lump	❑ Glaucoma	❑ Measles	❑ Psychiatric Care	❑ Venereal Disease
❑ Broken Bones	❑ Goiter	❑ Menopausal Prob.	❑ Rheumatoid Arthritis	❑ Whooping Cough
❑ Bronchitis	❑ Gonorrhea	❑ Migraines	❑ Rheumatic Fever	❑ Other: _____
❑ Bulimia	❑ Gout	❑ Miscarriage	❑ Scarlet Fever	_____
	❑ Heartburn	❑ Mononucleosis		_____
				_____

Is child currently under drug and/or medical care? ❑ Yes ❑ No If yes, explain _____

_____

Please list any and all medications child is currently taking: _____

_____

Please list any surgeries and/or hospitalizations child has had (type & date): _____

_____

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ALLERGIES: (Please place a check mark next to any known allergy that child has.) ☐ CHILD HAS NO KNOWN ALLERGIES

___ Milk ___Eggs ___Peanuts ___Almonds ___Cashews ___Walnuts ___ Fish ___ Shellfish ___Soy ___Wheat
___ Gluten ___Penicillin ___Sulfa Drugs ___Tetracycline ___Codeine ___NSAIDS ___Phenytoin ___Carbamazepine
___Mildew ___Mold ___ Dust ___Fungus ___Mites ___Tree Pollen ___Grass Pollen ___Weed Pollen ___Insects
___Dog Dander ___Cat Dander ___Latex ___Other Animal Dander ___ OTHER: _____ *(please fill in)*

Please list any supplements child is currently taking (vitamins/herbs/minerals): _____

Is there a family history of any of the following conditions? *(indicate family member including parents, grandparents & siblings)*
❑ Heart Disease _____ ❑ Diabetes _____
❑ Cancer _____ ❑ Arthritis _____ ❑ Other _____

Does child exercise: ❑ Frequently ❑ Moderately ❑ Occasionally ❑ None

What is child's daily/weekly intake of the following:

Caffeine _____ cups/day Soda _____ drinks/week Sports Drink/Juice _____ cups/day

I certify that the above questions were answered accurately. I understand that providing incorrect information can be dangerous to my child's health. I will give complete and accurate information during my child's exam.

I declare under penalty of perjury (under the laws of the United States of America) that the foregoing is true and correct: I am not attempting to investigate Suncoast Physical Medicine, LLC as a representative of any agency or entity, or any insurance company or other organizational entity or person.

Parent/Guardian Name _____ Signature _____
Date _____

X-ray Questionnaire: <u>For women only</u>

Our consultation and examination may indicate that x-rays are necessary to accurately diagnose and analyze your condition. Should x-rays be necessary we would like to confirm that you are not pregnant at this time.

☐ There is a possibility that my child may be pregnant at this time.

☐ Yes, my child is definitely pregnant ☐ No, my child is definitely not pregnant

☐ I request that x-ray films not be taken because: _____
_____

Date of last menstrual period: _____

_____ _____
Parent/Guardian Signature Date

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