Dr. Tyler Munn, D.C

Ages 4-12

PATIENT INTAKE FORM

Welcome! Our mission at Munn Chiropractic is to help as many people as possible to regain and maintain their health through chiropractic care in Aurora. We are passionate believers that "the power that made the body heals the body", and that when given the proper environment and care- through balancing structure and neurology with function and nutrition, the body will heal on its own as God created it to. We are a family-based chiropractic practice and love to help people of all ages- from their first breath to their last. We desire to see people in his community living healthier, more abundant lives. We're excited to serve, educate, empower, love, and positively impact the lives of those in our community and beyond.

CHILD'S INFORMATION

Name:	
Address:	
City:	State/Zip Code:
Parent's Cell Number:	
Parent's Email:	
Date of birth:	Age:
Weight:	Height:
Gender: ☐male ☐female	
Name of parent (s)/ guardian (s):	

How did you hear about our office?
☐**social media** ☐**google** ☐**friend:**_____ ☐**other:** _____

PURPOSE FOR VISIT

Purpose for this visit: ☐wellness ☐specific condition
If specific condition, describe:

Is the purpose of this visit related to:
☐sports ☐auto ☐fall ☐home injury ☐other
Please explain:

When did this condition begin?

Has this condition:
☐ gotten worse ☐stayed constant ☐come and gone

Does this condition interfere with:
☐sleep ☐daily routine ☐other activities
Please explain:

Has this condition occurred before? ☐yes ☐no
Please explain:

Have you seen other doctors/chiropractors for this condition?
☐ yes ☐no Type of treatment:_____

CHILD'S CURRENT HEALTH

Are you content with your child's present level of health?
☐yes ☐ no If yes, explain:

Is your child currently taking any medications?
If yes, please list along with the reason why:

Has your child taken any medications or antibiotics for an extended period of time in the past? If yes, please list along with the reason why:

Does your child take any herbal or vitamin supplementation? If yes, please list:

Has your child had any vaccines? ☐yes ☐no

Describe any and all reactions to vaccine(s):

Childhood illnesses:
☐ chicken pox__age ☐rubella __age
☐ mumps__ age ☐whooping cough __ age
If other, please list: _____

Has your child ever had bone fractured or joint dislocated? ☐ yes ☐no
If yes, please explain:

Has your child ever been in a car accident? ☐ yes ☐no
If yes, please explain:

Has your child ever been hospitalized? ☐yes ☐no
If yes, please explain:

CHILD'S CURRENT HEALTH

Does your child have difficulty interacting with others?
☐ yes ☐ no If yes, please explain:

Have you or anyone noticed that your child is nervous, twitches, shakes, or exhibits rocking behavior?
☐ yes ☐ no If yes, please explain:

Does your child ever bang his/her head repeatedly against a wall, bed, or other object?
☐ yes ☐ no If yes, please explain:

Is/was your child involved in any impact or contact sports? If yes, please list: (soccer, football, gymnastics, baseball, roller or ice hockey, lacrosse, etc.)

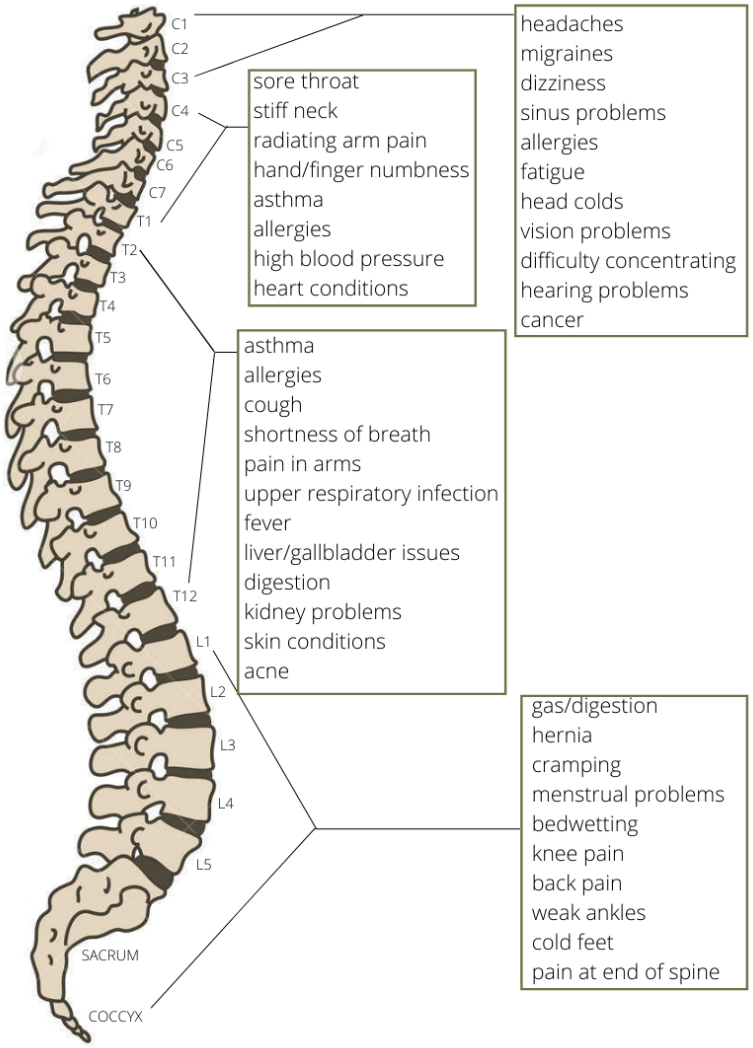
Please rate your child's stress levels on a scale of 1-10: (10 = high)
School: 1 2 3 4 5 6 7 8 9 10
Personal: 1 2 3 4 5 6 7 8 9 10
Please explain:

What changes (if any) in your child's health or behavior would you like accomplished?

ADDITIONAL COMMENTS OR CONCERNS

YOUR CONCERNS

Please circle health concerns or condition your child may be experiencing now or have in the past. Each area of concern relates to an area of the spine and nerve function.



INFORMED CONSENT FOR TREATMENT

Physicians and other health care providers are required to obtain your informed consent before starting treatment.
By signing below I do hereby give my consent to the performance of chiropractic treatment that may consist of manipulations/adjustments, physical medicine, exercises and traction. I understand that the manipulations/adjustments will involve movement of the joints and soft tissues that is considered to be one of the safest and most effective forms of therapy for musculoskeletal problems.
I am aware that there are possible risks/complications associated with my treatment. Tests have been performed to minimize these risks. I freely assume the risks of treatment after having been informed of the possible risks/complications associated with my treatment as follows:
• Soreness: It is common to experience muscle soreness during treatment
• Uncomfortableness: Temporary symptoms (dizziness, nausea) can occur, but are rare.
• Fractures/Joint Injury: Underlying physical defects, deformities or pathologies (osteoporosis) may cause susceptibility to injury.
• C.V.A.: Cerebral vascular accidents from chiropractic adjustments are extremely rare.

Treatment Results

I understand there are benefits associated with treatment including decreased pain, improved mobility and function and reduced muscle spasms. However, I also understand there is no guarantee that I will achieve these benefits during my care, as the practice of medicine, including chiropractic, is not an exact science.

Alternative Treatment Available

Reasonable alternatives to treatment have been explained to me including rest, home therapy, exercises medication and possible surgery. I agree to treatment by my doctor and such persons of the doctor's choosing, and hereby provide my informed consent for treatment.

I HAVE READ OR HAVE HAD READ TO ME THE ABOVE EXPLANATION OF CHIROPRACTIC TREATMENT. ANY QUESTIONS REGARDING TREATMENT HAVE BEEN ANSWERED TO MY SATISFACTION.

AUTHORIZATION

Additionally this office may use your name, address and/or telephone number for the purposes of contacting you to remind you about scheduled appointments, reevaluations, other appointment issues, newsletters, flyers, birthday cards, thank you cards, health related meetings, and/or Advanced talks/classes. During the course of your care with Munn Chiropractic it may be the desire of our office to request the use of your name for our referral/thank you board(s) and/or to obtain a patient testimonial or patient photo for the purpose of promoting chiropractic. This authorization may be revoked by you, the patient, at any time. Revocation may be accomplished by advising us in writing of your desire to withdraw your authorization. Please allow a reasonable processing time for the change in our procedures to be completed.
Your signature indicates your authorization and consent of the above described.

POLICIES

1. All first visit charges are payable when services are rendered.
2. The fee paid for treatment x-rays is for analysis only. X-rays are the property of this office and are used for treatment purposes. A copy of your x-rays may be requested today for only $20. Furthermore, I understand Munn Chiropractic will prepare any necessary reports and forms to assist in making collections from the insurance company and that any amount authorized to be paid directly to Munn Chiropractic will be credited to my account upon receipt. However, I clearly understand and agree that all my services rendered me are charged directly to me and that I am responsible for payment.

I also understand that if I suspend or terminate my care at this office, any outstanding charges for professional services rendered me will be immediately due and payable. I agree that I will be responsible for all attorney and legal fees if legal action becomes necessary to collect this account. If an account balance remains unpaid for three months or longer, a monthly interest fee of 2% will apply to account balance. I authorize Munn Chiropractic to obtain a credit report if deemed necessary.

Please Note: This will be our only notice to you. Due to our efforts to keep costs down and control our outstanding accounts, all accounts over 30 days past due are subject to collection agency procedures and additional costs.

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective. Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion and disappointment.
Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.
Health: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.
Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.
We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others.
OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.
By signing below I have read and fully understand the above statements.

PATIENT PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW CHIROPRACTIC AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. Please see back side for complete details. by signing below you have read and fully understanding this notice.

Printed Name _____

Signature _____ Date _____

Parent Guardian _____

PATIENT PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW CHIROPRACTIC AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

In the course of your care as a patient at Munn Chiropractic we may use or disclose personal and health related information about you in the following ways:
• Your personal health information, including your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.
• Your health care records as well as your billing records may be disclosed to another party, such as an insurance carrier, an HMO, a PPO, or your employer, if they are or may be responsible for the payment of your services.
• Your name, address, phone number and your health care records may be used to contact you regarding appointment reminders, information about alternatives to your present care, or other health related information that may be of interest to you.
If you are not at home to receive an appointment reminder, a message may be left on your answering machine. Further, you have the right to inspect or obtain a copy of the information we will use for these purposes. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization it will not affect the care provided to you or the reimbursement avenues associated with your care.

We normally provide information about your health to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your health care or about the status of your account. If you would like to receive this information at an address other than your home or, if you would like the information in a different form please advise us in writing as to your preferences.

Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in these following circumstances:
• If we are providing health care services to you based on the orders of another health care provider.
• If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.
• If there are substantial barriers communicating with you, but in our professional judgment we believe you intend for us to provide care.
• If we are ordered by the courts or another appropriate agency.

Any use or disclosure of your protected health information, other than as outlined above, will only be made upon your written authorization.

You have the right to inspect and/or copy your health information for seven years from the date that the record was created or as long as the information remains in our files. In addition, you have the right to request an amendment to your health information. Requests to inspect, copy or amend your health related information should be provided to us in writing.

We are required by state and federal law to maintain the privacy of your patient file and the protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information.

We are further required by law to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice we will notify you in writing as soon as possible following the changes. Any change in our privacy notice will apply for all of your health information in our files.

Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

If you have a complaint regarding our privacy notice, our privacy practices or any aspect of activities you should direct your complaint to the Privacy Officer, Tyler Munn, D.C. at 14 New Hudson Rd Ste. D, Aurora, OH 44202, (330) 954-9392. If you would like further information about our privacy policies and practices please contact: Tyler Munn, D.C.

This office utilizes an “open treatment” environment for ongoing patient care. “Open treatment” involves the possibility of other patients being seen in the same “treatment environment” at the same time. Patients are within sight of one another and some ongoing routine details of care are discussed within hearing of other patients and staff. A private, closed and confidential setting is provided for history taking, examinations, report of findings, etc. as determined by the doctor or staff. The use of this format is intended to make your experience with our office more efficient and productive as well as to enhance your access to quality health care and health information. If you choose not to be adjusted or use traction in an “open treatment” environment other arrangements will be made for you. This office also requests the presence of your spouse or significant other at your Doctor’s Report Appointment for purposes of health education. My signature acknowledges that I have received a copy of this notice.

Printed Name _____

Signature _____ Date _____

Parent Gaurdian _____