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# PEDIATRIC INTAKE FORM

Build A Healthy Foundation.

## Welcome to the Summit Family Chiropractic community!

(For any question that does not apply to your child, simply respond "N/A" for Not Applicable.)

Today's Date: \_\_\_\_\_

Has your child ever received chiropractic care?  No  Yes, (Name of Doctor): \_\_\_\_\_

Has anyone in your child's family ever received chiropractic care?  No  Yes, (Name of Doctor): \_\_\_\_\_

## PERSONAL INFORMATION

Child's Full Name: \_\_\_\_\_

Child's Preferred Name: \_\_\_\_\_

Male  Female

Weight: \_\_\_\_\_ lb. \_\_\_\_\_ oz. Height: \_\_\_\_\_ ft. \_\_\_\_\_ in.

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_

Zip: \_\_\_\_\_

List Your Child's Regular Physical Activities:

\_\_\_\_\_

List Your Child's Hobbies & Interests:

\_\_\_\_\_

List The Name(s) & Age(s) of Your Child's Sibling(s):

\_\_\_\_\_

Full Name of Parent/Guardian #1:

Phone: \_\_\_\_\_  Home  Work  Cell

Email: \_\_\_\_\_

Occupation: \_\_\_\_\_

Employer: \_\_\_\_\_

Full Name of Parent/Guardian #2:

Phone: \_\_\_\_\_  Home  Work  Cell

Email: \_\_\_\_\_

Occupation: \_\_\_\_\_

Employer: \_\_\_\_\_

Family Member(s) Responsible For Finances:

Parent/Guardian #1  Parent/Guardian #2

Both Parents/Guardians #1 & #2

Other: \_\_\_\_\_

Other's Phone #: \_\_\_\_\_

## INSURANCE INFORMATION

Select which is true for your child:  Self Pay  Insured, (With the following insurance)

Primary Insurance: \_\_\_\_\_

Member ID #: \_\_\_\_\_

Policy Holder's Name: \_\_\_\_\_

Policy Holder's Date of Birth: \_\_\_\_\_

Policy Holder's Employer: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_

Member ID #: \_\_\_\_\_

Policy Holder's Name: \_\_\_\_\_

Policy Holder's Date of Birth: \_\_\_\_\_

Policy Holder's Employer: \_\_\_\_\_

## HEALTH GOALS

Check all of the current health and lifestyle goals for your child:

Improve Posture

Get Adequate Sleep

Drink More Water

Increase Energy

Improve Diet/Nutrition

Improve Focus/Concentration

Increase Self Confidence

Restore Emotional Health

Strengthen Immune System

Maintain Healthy Body Weight

Improve Athletic Performance

Other: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## CASE HISTORY

Has your child ever had an operation?  No  Yes, (List all operation(s) including the year): \_\_\_\_\_

Has your child ever had a serious illness or health emergency?  No  Yes, (List all condition(s) including the year): \_\_\_\_\_

Does your child have any genetic disorders or disabilities?  No  Yes, (Explain): \_\_\_\_\_

Does your child have any allergies?  No  Yes, (Explain): \_\_\_\_\_

Has your child ever been in an auto accident?  No  Yes, (Include the year): \_\_\_\_\_

Has your child ever been unconscious?  No  Yes, (Explain): \_\_\_\_\_

Has your child ever fractured a bone?  No  Yes, (Explain): \_\_\_\_\_

Has your child ever taken an antibiotic drug?  No  Yes, (Include times per lifetime): \_\_\_\_\_

Is your child taking any over-the-counter or prescription drug, vitamin / supplement, or natural remedy?  
 No  Yes, (Please list the name & reason for taking): \_\_\_\_\_

## PRENATAL HISTORY

**Complete this section if your child is younger than 5 years of age.**

Name of  Obstetrician /  Midwife: \_\_\_\_\_

Ultrasounds during pregnancy?  No  Yes, (How many?): \_\_\_\_\_

Complications during pregnancy / delivery?  No  Yes, (Explain): \_\_\_\_\_

List any drug / medication, vitamin / supplement, or natural remedy taken during pregnancy / delivery: \_\_\_\_\_

Location of birth:  Hospital  Birthing Center  Home  Other: \_\_\_\_\_

Childbirth delivery method:  Vaginal  Planned Cesarean Section  Emergency Cesarean Section

Vaginal Birth After Cesarean  Vacuum Extraction  Forceps

Birth Weight: \_\_\_\_\_ Birth Length: \_\_\_\_\_ APGAR Scores: \_\_\_\_\_ - \_\_\_\_\_

Was / is your child breast fed?  No  Yes, (For how long?): \_\_\_\_\_

Was / is your child formula fed?  No  Yes, (For how long?): \_\_\_\_\_ Formula type: \_\_\_\_\_

Was your child introduced to cow's milk?  No  Yes, (At what age?): \_\_\_\_\_

According to the National Safety Council, approximately 50% of children fall head first from a high place during their first years of life (i.e. a bed, changing table, down stairs) Did your child have a fall similar to this?  
 No  Yes, Explain: \_\_\_\_\_

## CURRENT SYMPTOMS

Select which is true for your child:

My child **DOES NOT** have symptoms. I am seeking chiropractic care to maintain wellness.

(If checked, move ahead to the "INITIAL ASSESSMENT" section)

My child **DOES** have symptoms.

Check all of the symptom(s) that has you seeking chiropractic care for your child:

ADHD/ADD

Autism

Ear Infections

Restless Sleep

Allergies

Back Pain

Epilepsy

Scoliosis

Anxiety

Bed Wetting

Growing Pains

Temper Tantrums/Moody

Asthma

Colic

Headaches

Other: \_\_\_\_\_

Athletic Injury

Digestive Problems

Recurring Colds/Fevers

When did your child's symptom(s) begin?  Today  Days Ago  Weeks Ago  Months Ago  Years Ago

Did your child's symptom(s) begin as a result of an injury?  No  Yes, (Explain): \_\_\_\_\_

What have you already tried that **HAS NOT** helped to relieve your child's symptom(s)? \_\_\_\_\_

What have you already tried that **HAS** helped to relieve your child's symptom(s)? \_\_\_\_\_






# INITIAL ASSESSMENT

NAME: \_\_\_\_\_ DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_

Select which is true for your child.

- My child **DOES NOT** have symptoms. (If checked, move ahead to the "STRESS ASSESSMENT" section.)  
 My child **DOES** have symptoms. (If checked, use the "EFFECT SCALE" to answer the "SELF RATING" questions.)

## EFFECT SCALE

|  |  |   |   |   |          |          |   |          |          |   |
|--|--|---|---|---|----------|----------|---|----------|----------|---|
|   |   |  |  |    |          |          |   |          |          |   |
| <b>0</b>   | <b>1</b>   | <b>2</b>  | <b>3</b>  | <b>4</b>  | <b>5</b> | <b>6</b> | <b>7</b>  | <b>8</b> | <b>9</b> | <b>10</b>   |
| <b>NO EFFECT</b>   | <b>MILD EFFECT</b>   |   |   | <b>MODERATE EFFECT</b>  |          |          | <b>LIMITING EFFECT</b>  |          |          | <b>SEVERE EFFECT</b>  |
| I am free from any symptom. I can do all of my daily activities. My quality of life is good. I am grateful for my good health. | I barely notice the symptom. I can do most of my daily activities. I don't think much about the symptom, but it does cause me some discomfort. |   |   | I notice the symptom and it causes me distress. I can do some of my daily activities. I can only ignore the symptom for a short period of time. |          |          | I experience constant distress from the symptom. I am unable to do many of my daily activities. I can not ignore the symptom, it disrupts my ability to think clearly, hold a job, and maintain social relationships. |          |          | I am in distress and excruciating pain from the symptom. I am unable to do any of my daily activities. I am weak, delirious and bedridden. (Very few people ever experience this level of pain. Suicide is often considered.) |

## SELF RATING

What is your child's main symptom for seeking chiropractic care? **Write it here:** \_\_\_\_\_

| For each statement below, place an "X" in the "RATING" box to best show how the symptom effects your child. | RATING |   |   |   |   |   |   |   |   |   |    |
|---|--------|---|---|---|---|---|---|---|---|---|----|
|   | 0      | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| ON AVERAGE, rate the effect of your child's symptom.  |        |   |   |   |   |   |   |   |   |   |    |
| RIGHT NOW, rate the effect of your child's symptom.   |        |   |   |   |   |   |   |   |   |   |    |
| AT ITS BEST, rate how close to "0" your child's symptom gets.   |        |   |   |   |   |   |   |   |   |   |    |
| AT ITS WORST, rate how close to "10" your child's symptom gets.   |        |   |   |   |   |   |   |   |   |   |    |

If your child has a second symptom for seeking chiropractic care, **write it here:** \_\_\_\_\_

| For each statement below, place an "X" in the "RATING" box to best show how the symptom effects your child. | RATING |   |   |   |   |   |   |   |   |   |    |
|---|--------|---|---|---|---|---|---|---|---|---|----|
|   | 0      | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| ON AVERAGE, rate the effect of your child's symptom.  |        |   |   |   |   |   |   |   |   |   |    |
| RIGHT NOW, rate the effect of your child's symptom.   |        |   |   |   |   |   |   |   |   |   |    |
| AT ITS BEST, rate how close to "0" your child's symptom gets.   |        |   |   |   |   |   |   |   |   |   |    |
| AT ITS WORST, rate how close to "10" your child's symptom gets.   |        |   |   |   |   |   |   |   |   |   |    |

If your child has a third symptom for seeking chiropractic care, **write it here:** \_\_\_\_\_

| For each statement below, place an "X" in the "RATING" box to best show how the symptom effects your child. | RATING |   |   |   |   |   |   |   |   |   |    |
|---|--------|---|---|---|---|---|---|---|---|---|----|
|   | 0      | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| ON AVERAGE, rate the effect of your child's symptom.  |        |   |   |   |   |   |   |   |   |   |    |
| RIGHT NOW, rate the effect of your child's symptom.   |        |   |   |   |   |   |   |   |   |   |    |
| AT ITS BEST, rate how close to "0" your child's symptom gets.   |        |   |   |   |   |   |   |   |   |   |    |
| AT ITS WORST, rate how close to "10" your child's symptom gets.   |        |   |   |   |   |   |   |   |   |   |    |

## STRESS ASSESSMENT

Check all of the stresses you have experienced in the past 3 months:

- |  |  |   |  |
|--|--|---|--|
| <input type="checkbox"/> Slip / Falls  | <input type="checkbox"/> Poor Diet / Nutrition | <input type="checkbox"/> Lack of Sleep        | <input type="checkbox"/> Emotional Stress    |
| <input type="checkbox"/> Car Accident  | <input type="checkbox"/> Excessive Sitting     | <input type="checkbox"/> Death of A Loved One | <input type="checkbox"/> Occupational Stress |
| <input type="checkbox"/> Sports Injury | <input type="checkbox"/> Excessive Standing    | <input type="checkbox"/> Hospitalization      | <input type="checkbox"/> Financial Stress    |
| <input type="checkbox"/> Depression    | <input type="checkbox"/> Lack of Exercise      | <input type="checkbox"/> Surgery / Operation  | <input type="checkbox"/> Other: _____        |
| <input type="checkbox"/> Anxiety       | <input type="checkbox"/> Increase of Exercise  | <input type="checkbox"/> Change In Medication | _____  |

## ACTIVITIES OF DAILY LIVING

Complete if older than 5 years of age.

Based on the "EFFECT SCALE" rate how each activity effects you (or your child).

Place an "X" in the box to mark your rating. Use "N/A" for any activity Not Applicable to you (or your child).

### PERSONAL HYGIENE & DAILY CARE

| ACTIVITY                | RATING |   |   |   |   |   |   |   |   |   |   | ADDITIONAL NOTES: |    |  |
|-------------------------|--------|---|---|---|---|---|---|---|---|---|---|-------------------|----|--|
|                         | N/A    | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |                   | 10 |  |
| Bathing / Showering     |        |   |   |   |   |   |   |   |   |   |   |                   |    |  |
| Grooming Hair           |        |   |   |   |   |   |   |   |   |   |   |                   |    |  |
| Brushing Teeth          |        |   |   |   |   |   |   |   |   |   |   |                   |    |  |
| Using The Toilet        |        |   |   |   |   |   |   |   |   |   |   |                   |    |  |
| Dressing The Upper Body |        |   |   |   |   |   |   |   |   |   |   |                   |    |  |
| Dressing The Lower Body |        |   |   |   |   |   |   |   |   |   |   |                   |    |  |

### DAILY PHYSICAL ACTIVITIES

| ACTIVITY                      | RATING |   |   |   |   |   |   |   |   |   |   | ADDITIONAL NOTES: |    |  |
|-------------------------------|--------|---|---|---|---|---|---|---|---|---|---|-------------------|----|--|
|                               | N/A    | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |                   | 10 |  |
| Standing                      |        |   |   |   |   |   |   |   |   |   |   |                   |    |  |
| Sitting                       |        |   |   |   |   |   |   |   |   |   |   |                   |    |  |
| Squatting                     |        |   |   |   |   |   |   |   |   |   |   |                   |    |  |
| Kneeling                      |        |   |   |   |   |   |   |   |   |   |   |                   |    |  |
| Reaching Overhead             |        |   |   |   |   |   |   |   |   |   |   |                   |    |  |
| Bending Forward               |        |   |   |   |   |   |   |   |   |   |   |                   |    |  |
| Turning Left                  |        |   |   |   |   |   |   |   |   |   |   |                   |    |  |
| Turning Right                 |        |   |   |   |   |   |   |   |   |   |   |                   |    |  |
| Move From Lying to Sitting    |        |   |   |   |   |   |   |   |   |   |   |                   |    |  |
| Move From Sitting to Standing |        |   |   |   |   |   |   |   |   |   |   |                   |    |  |
| Move From Standing to Sitting |        |   |   |   |   |   |   |   |   |   |   |                   |    |  |

### FUNCTIONAL ACTIVITIES

| ACTIVITY                 | RATING |   |   |   |   |   |   |   |   |   |   | ADDITIONAL NOTES: |    |  |
|--------------------------|--------|---|---|---|---|---|---|---|---|---|---|-------------------|----|--|
|                          | N/A    | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |                   | 10 |  |
| Sleeping                 |        |   |   |   |   |   |   |   |   |   |   |                   |    |  |
| Eating                   |        |   |   |   |   |   |   |   |   |   |   |                   |    |  |
| Going Up & Down Stairs   |        |   |   |   |   |   |   |   |   |   |   |                   |    |  |
| Getting In & Out of Care |        |   |   |   |   |   |   |   |   |   |   |                   |    |  |
| Driving                  |        |   |   |   |   |   |   |   |   |   |   |                   |    |  |
| Using A Computer         |        |   |   |   |   |   |   |   |   |   |   |                   |    |  |
| Focusing/ Concentrating  |        |   |   |   |   |   |   |   |   |   |   |                   |    |  |
| Preparing Food           |        |   |   |   |   |   |   |   |   |   |   |                   |    |  |
| Household Chores         |        |   |   |   |   |   |   |   |   |   |   |                   |    |  |
| Lifting Children         |        |   |   |   |   |   |   |   |   |   |   |                   |    |  |
| Carrying Bag / Purse     |        |   |   |   |   |   |   |   |   |   |   |                   |    |  |

### SOCIAL, RECREATIONAL, & OTHER ACTIVITIES

| ACTIVITY                    | RATING |   |   |   |   |   |   |   |   |   |   | ADDITIONAL NOTES: |    |  |
|-----------------------------|--------|---|---|---|---|---|---|---|---|---|---|-------------------|----|--|
|                             | N/A    | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |                   | 10 |  |
| Competitive Sports          |        |   |   |   |   |   |   |   |   |   |   |                   |    |  |
| Running / Jogging / Hiking  |        |   |   |   |   |   |   |   |   |   |   |                   |    |  |
| Other Recreation Activities |        |   |   |   |   |   |   |   |   |   |   |                   |    |  |
| Hobbies                     |        |   |   |   |   |   |   |   |   |   |   |                   |    |  |
| Sexual Activity             |        |   |   |   |   |   |   |   |   |   |   |                   |    |  |

SIGNATURE: \_\_\_\_\_

## FAMILY HEALTH HISTORY

Place an "X" in the box below to show if your child's family members have ever had the following conditions.

- If there is more than one family member per category, use an "X" to represent each individual.
- If you are filling this form out for your child, use "SELF" to represent your child's conditions.

| CONDITION                      | SELF | SIBLING(S) | FATHER | MOTHER |
|--------------------------------|------|------------|--------|--------|
| Acid Reflux / Heartburn / GERD |      |            |        |        |
| ADD / ADHD                     |      |            |        |        |
| Allergies                      |      |            |        |        |
| Anxiety                        |      |            |        |        |
| Arthritis / Joint Pain         |      |            |        |        |
| Asthma / Difficulty Breathing  |      |            |        |        |
| Bed Wetting                    |      |            |        |        |
| Birth Defect                   |      |            |        |        |
| Cancer                         |      |            |        |        |
| Colic                          |      |            |        |        |
| Convulsions / Epilepsy         |      |            |        |        |
| Deceased                       |      |            |        |        |
| Depression                     |      |            |        |        |
| Diabetes                       |      |            |        |        |
| Digestive Problems             |      |            |        |        |
| Disc Problems                  |      |            |        |        |
| Ear Problems / Hearing loss    |      |            |        |        |
| Fibromyalgia / Muscle Pain     |      |            |        |        |
| Frequent Cold / Flu            |      |            |        |        |
| Gall Bladder Problems          |      |            |        |        |
| Headache / Migraines           |      |            |        |        |
| Heart Problems                 |      |            |        |        |
| High / Low Blood Pressure      |      |            |        |        |
| HIV / AIDS                     |      |            |        |        |
| Impotence / Sexual Dysfunction |      |            |        |        |
| Kidney Problems                |      |            |        |        |
| Learning Disability            |      |            |        |        |
| Liver Problems                 |      |            |        |        |
| Menstrual Dysfunction          |      |            |        |        |
| Mood Changes / Irritable       |      |            |        |        |
| Neck Pain / Back Pain          |      |            |        |        |
| Prostate Problems              |      |            |        |        |
| Sciatica                       |      |            |        |        |
| Scoliosis                      |      |            |        |        |
| Sinus / Drainage Problems      |      |            |        |        |
| Skin Problems                  |      |            |        |        |
| Sleep Problems                 |      |            |        |        |
| Thyroid Problems               |      |            |        |        |
| Tremors                        |      |            |        |        |
| Vertigo / Dizziness            |      |            |        |        |
| Vision Problems                |      |            |        |        |
| Other:                         |      |            |        |        |

## TERMS OF ACCEPTANCE

Here at Summit Family Chiropractic the term Practice Member is used instead of “patient” as “patient” suggests illness or injury, and many whom we serve are healthy and seeking wellness rather than symptom management. A Practice Member is an active participant in his or her chiropractic care, and is therefore invited to ask any questions or express any concerns that he or she may have. Practice Members can expect quality service and leadership as they regain control of their health. With the utilization of state of the art advanced technology, a complete analysis of your child’s spine will be administered first to detect the presence of vertebral subluxation complex and to monitor your child’s progress. Please read and sign this form stating that you understand the items explained below. If there is anything that is unclear please ask questions before you sign. If you refuse to sign this form the doctor reserves the right to refuse care.

## INFORMED CONSENT FOR CHIROPRACTIC CARE

I hereby consent to give the doctor of chiropractic, and anyone working in the Summit Family Chiropractic office authorized by the chiropractor, permission and authority to care for my child (the minor listed here: \_\_\_\_\_ for whom I am legally responsible). Chiropractic tests, diagnosis, analysis, and adjustments are very safe and beneficial and rarely cause any risks. In rare cases, underlying physical defects, deformities or pathologies may make your child prone to injury. It is the responsibility of the child’s parent/guardian to make it known, or to learn through health care procedures if your child is suffering from latent pathological defects, illnesses, or deformities, which would otherwise not come to the attention of the chiropractor. The doctor of chiropractic will not give any treatment or care if he or she is aware that such care should not be used for a particular condition or circumstance. Your child’s doctor of chiropractic is a licensed primary care provider, and is available to work with all other types of providers. I understand that if my child is accepted as a Practice Member at Summit Family Chiropractic, I am authorizing them to proceed with any treatment that they deem necessary. I understand that following the doctor’s recommend care plan is essential to maximizing my child’s healing and reaching optimal health through chiropractic. Furthermore, any questions that I have regarding chiropractic care, will be explained to me upon my request.

## AUTHORIZATION FOR X-RAYS

Specific postural x-rays may be necessary for the identification of the location, type, and severity of vertebral subluxation, as well as for the diagnosis and identification of latent or dangerous conditions requiring medical attention. X-rays may also be used to show progress after a period of recommended chiropractic care. At your request, you can received a copy of your child’s x-rays to a disc for the mandated fee of \$15.00.

By signing below, I authorize to perform diagnostic x-rays of my child if medically necessary.

### Select which is true for your female child:

- To the best of my knowledge, there is no chance that my child is pregnant at this time.
- I know or believe that my child may be pregnant at this time and therefore I **DO NOT** authorize Summit Family Chiropractic to perform diagnostic x-rays of her.

## AUTHORIZATION FOR RELEASE OF INFORMATION & ASSIGNMENT OF BENEFIT

By signing below, I recognize that I am financially responsible for all services rendered to my child regardless of insurance or benefit. I further understand that any health insurance policy is an arrangement between me and my child’s insurance carrier and that I may be required to pay for some or all of the fees charged to my child’s account. I hereby authorize Summit Family Chiropractic LLC to release all necessary information concerning my child’s health condition to any billing company, insurance company, attorney, and/or adjuster in order to process any claim for reimbursement of charges incurred by my child. In addition I authorize Summit Family Chiropractic LLC to release any information regarding my child’s health condition to other health care providers involved in my child’s care. This assignment will remain in effect until revoked by me in writing. I agree that a photocopy of this form is to be considered as valid as the original. I confirm that all information I have provided is true and correct to the best of my knowledge. I confirm that I have read and fully understand this agreement and authorize Summit Family Chiropractic LLC to proceed with chiropractic care.

Signature of Practice Member or Parent/Guardian

Date

## NOTICE OF PRIVACY PRACTICES

This notice describes how health information about your child may be used and disclosed and how you can get access to your child's health information and records.

Summit Family Chiropractic, understands the importance of privacy and we are committed to maintaining the confidentiality of your child's protected health information (PHI) in compliance with the Health Insurance Portability and Accountability Act of 1996 (**HIPAA**). We have developed office policies and procedures that protect your child's personal and health information when used within our office and any devices used to copy or transfer this data. We assure you that your child's information will only be shared as required and only for the purpose of administering your child's case and obtaining payment for services. Be assured that without your permission, your child's health information will not be used for any other purpose.

The following ways are how your child's PHI may be used within our office to provide you the best care and services possible:

- To provide treatment, obtain payment, and conduct health care operations.
- To schedule appointments and send reminders.
- To communicate with your child's family, friends, and/or caregivers with your authorization.
- As permitted or required by the law.
- For certain activities when the law requires it.

The following describes your rights regarding your child's (PHI). You may:

- Request to inspect any copy of your child's records.
- Request to amend incomplete or inaccurate information in your child's records.
- Receive an accounting of certain disclosures of your child's health information.
- Ask for additional privacy protections (although your request may be declined).
- Ask for confidential communications in a particular manner.
- Receive a paper copy of this Notice.
- File a complaint without penalty

Summit Family Chiropractic reserves the right to change this privacy policy as allowed by law and to make the new notice apply to health information already received as well as any information received in the future. A copy of our current notice is available upon request. The notice will contain the effective date.

If you believe that we have not properly respected the privacy of your child's PHI, you may file a complaint with our office by calling (615)-583-9788, sending a letter to our office address: 11227 Lebanon Rd Mount Juliet, TN 37122 or by emailing [infosfctn@gmail.com](mailto:infosfctn@gmail.com).

I confirm that I have received and reviewed this notice and understand how health information about my child may be used and disclosed and how I can get access to my child's health information and records.

---

Signature of Practice Member or Parent/Guardian

Date

## SOCIAL MEDIA CONSENT

Select an option below.

- I **DO** authorize Summit Family Chiropractic to display testimonials, photographs, and videos of my child in the office or on social media outlets. I understand that the purpose of sharing this information is to provide other's with chiropractic education and give hope to those seeking answers to their health concerns. My consent remains in effect until revoked by me in writing.
- I **DO NOT** authorize Summit Family Chiropractic to display testimonials, photographs, and videos of my child in the office or on social media outlets at this time.