Pediatric Patient Questionnaire

CONFIDENTIAL PATIENT INFORMATION

Child's Name: Parent/Guardian Name(s):

Street Address: City: State: Zip:

Cell Phone: - - Home Phone: - - Work Phone: - -

Email: Child's SS #: - - Birthdate: / / Age:

How did you hear about us? Height: ft. in. Weight: lbs.

Who is your primary care physician?

Is your child receiving care from any other health professionals? ◯ Yes ◯ No
- If yes, please name them and their specialty:

Please list any drugs/medications/vitamins/herbs/other that your child is taking:

CURRENT HEALTH CONDITIONS

What health condition(s) bring your child to be evaluated by a chiropractor?

When did the condition first begin? How did the problem start? ◯ Suddenly ◯ Gradually ◯ Post-Injury

Has your child ever received care for this condition before? ◯ Yes ◯ No
- If yes, please explain:

Is this condition: ◯ Getting worse ◯ Improving ◯ Intermittent ◯ Constant ◯ Unsure

What makes the problem better? What makes the problem worse?

HEALTH GOALS FOR YOUR CHILD

What are your top three health goals for your child:

1. _____
2. _____
3. _____

What would you like to gain from chiropractic care?

◯ Resolve existing condition
◯ Overall wellness
◯ Both

Have you ever visited a chiropractor? ◯ Yes ◯ No If yes, what is their name? _____

What is their specialty? ◯ Pain Relief ◯ Physical Therapy & Rehab ◯ Nutritional ◯ Subluxation-based ◯ Other:

PREGNANCY & FERTILITY HISTORY

Please tell us about your pregnancy

Any fertility issues? ◯ Yes ◯ No If yes, please explain: _____

Did mother smoke? ◯ Yes ◯ No If yes, how many per week? _____

Did mother drink? ◯ Yes ◯ No If yes, how many per week? _____

Did mother exercise? ◯ Yes ◯ No If yes, please explain: _____

Was mother ill? ◯ Yes ◯ No If yes, please explain: _____

Any ultrasounds? ◯ Yes ◯ No If yes, please explain: _____

Please explain any notable episodes of mental or physical stress during your pregnancy:

Please explain any other concerns or notable remarks about your child's conception or pregnancy:

LABOR & DELIVERY HISTORY

Child's birth was: ◯ Natural vaginal birth ◯ Scheduled C-section ◯ Emergency C-section At how many week's was your child born?

Child's birth was: ◯ At home ◯ At a birthing center ◯ At a hospital ◯ Other: Doctor/Obstetrician's Name:

Please check any applicable interventions or complications:

◯ Breech ◯ Induction ◯ Pain meds ◯ Epidural ◯ Episiotomy ◯ Vacuum extraction ◯ Forceps ◯ Other

Please describe any other concerns or notable remarks about your child's labor and/or delivery.

Child's birth weight: lbs. oz. Child's birth height: in. APGAR score at birth: APGAR score after 5 minutes:

GROWTH & DEVELOPMENT HISTORY

Is/was your child breastfed? ◯ Yes ◯ No If yes, how long? Difficulty with breastfeeding? ◯ Yes ◯ No

Did they ever use formula? ◯ Yes ◯ No If yes, at what age? If yes, what type?

Did/does your child ever suffer from colic, reflux, or constipation as an infant? ◯ Yes ◯ No
- If yes, please explain:

Did/does your child frequently arch their neck/back, feel stiff, or bang their head? ◯ Yes ◯ No
- If yes, please explain:

At what age did the child: Respond to sound: _____ Follow an object: _____ Hold their head up: _____ Vocalize: _____ Teethe: _____
Sit alone: _____ Crawl: _____ Walk: _____ Begin cow's milk: _____ Begin solid foods: _____

Please list any food intolerance or allergies, and when they began:

Please list your child's hospitalization and surgical history, including the year:

Please list any major injuries, accidents, falls and/or fractures your child has sustained in his/her lifetime, including the year:

Have you chosen to vaccinate your child? ◯ No ◯ Yes, on a delayed or selective schedule ◯ Yes, on schedule
- If yes, please list any vaccination reactions:

Has your child received any antibiotics? ◯ Yes ◯ No
- If yes, how many times and list reason:

Night terrors or difficulty sleeping? ◯ Yes ◯ No If yes, please explain:

Behavioral, social or emotional issues? ◯ Yes ◯ No If yes, please explain:

How many hours per day does your child typically spend watching a TV, computer, tablet or phone?

How would you describe your child's diet? ◯ Mostly whole, organic foods ◯ Pretty average ◯ High amount of processed foods

ACKNOWLEDGEMENT & CONSENT

Patient Signature: _____ Date: _____

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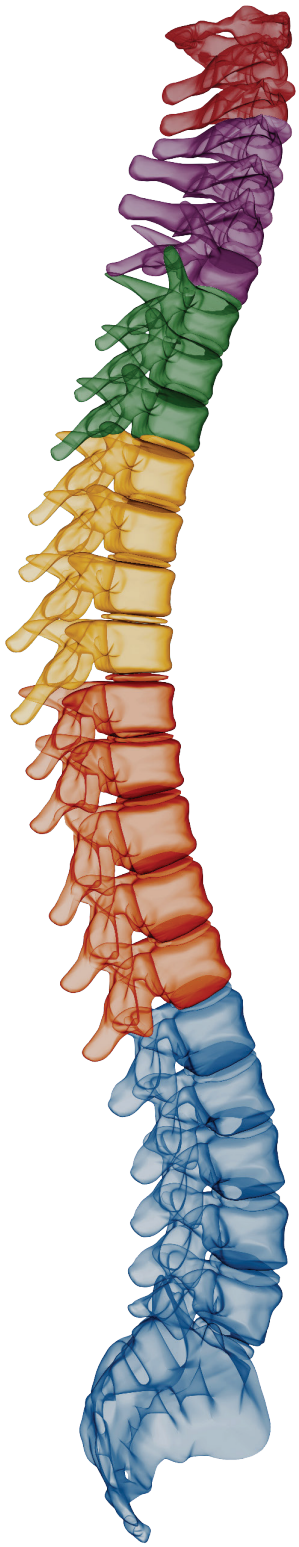
Patient Review of Systems

THE NERVOUS SYSTEM CONTROLS AND COORDINATES ALL ORGANS AND STRUCTURES OF THE HUMAN BODY

Please check the corresponding boxes for each symptom or condition you have experienced – including both past and present.



REGIONS	FUNCTIONS	SYMPTOMS			
		PAST	PRESENT	PAST	PRESENT
Cervical	• Autonomic Nervous System • ENT System • Vision, Balance & Coordination • Speech • Immune System • Digestive System • Nerve Supply to Shoulders, Arms & Hands • Sympathetic Nucleus • Metabolism	☐	☐ Colic & Excessive Crying	☐	☐ Epilepsy & Seizures
		☐	☐ Ear & Sinus Infections	☐	☐ Sensory & Spectrum
		☐	☐ Allergies & Congestion	☐	☐ ADD / ADHD
		☐	☐ Immune Deficiency	☐	☐ Focus & Memory Issues
		☐	☐ Headaches & Migraines	☐	☐ Anxiety & Stress
		☐	☐ Vertigo & Dizziness	☐	☐ Balance & Coordination
		☐	☐ Sore Throat & Strep	☐	☐ Speech Issues
		☐	☐ Swollen Tonsils & Adenoids	☐	☐ TMJ / Jaw Pain
		☐	☐ Vision & Hearing Issues	☐	☐ Stiff Neck & Shoulders
		☐	☐ Low Energy & Fatigue	☐	☐ Depression
		☐	☐ Difficulty Sleeping	☐	☐ High Blood Pressure
		☐	☐ Pain, Numbness & Tingling in Arms to Hands	☐	☐ Poor Metabolism & Weight Control
Upper Thoracic	• Upper G.I. • Respiratory System • Cardiac Function	☐	☐ Reflux / GERD	☐	☐ Bronchitis & Pneumonia
		☐	☐ Chronic Colds & Cough	☐	☐ Functional Heart Conditions
		☐	☐ Asthma		
Mid Thoracic	• Major Digestive Center • Detox & Immunity	☐	☐ Gallbladder Pain / Issues	☐	☐ Indigestion & Heartburn
		☐	☐ Jaundice	☐	☐ Stomach Pains & Ulcers
		☐	☐ Fever	☐	☐ Blood Sugar Problems
Lower Thoracic	• Stress Response • Filtration & Elimination • Gut & Digestion • Hormonal Control	☐	☐ Behavior Issues	☐	☐ Allergies & Eczema
		☐	☐ Hyperactivity	☐	☐ Skin Conditions / Rash
		☐	☐ Chronic Fatigue	☐	☐ Kidney Problems
		☐	☐ Chronic Stress	☐	☐ Gas Pain & Bloating
Lumbar, Sacrum & Pelvis	• Lower G.I. (Absorption & Motility) • Gut-Immune System • Major Hormonal Control	☐	☐ Constipation	☐	☐ Sciatica & Radiating Pain
		☐	☐ Chrohn's, Colitis & IBS	☐	☐ Lumbopelvic / SI Joint Pain
		☐	☐ Diarrhea	☐	☐ Hamstring Tightness
		☐	☐ Bed-wetting	☐	☐ Disc Degeneration
		☐	☐ Bladder & Urination Issues	☐	☐ Leg Weakness & Cramps
		☐	☐ Cramps & Menstrual Issues	☐	☐ Poor Circulation & Cold Feet
		☐	☐ Cysts & Endometriosis	☐	☐ Knee, Ankle & Foot Pain
		☐	☐ Infertility	☐	☐ Weak Ankles & Arches
		☐	☐ Impotency	☐	☐ Lower Back Pain
		☐	☐ Hemorrhoids	☐	☐ Gluten & Casein Intolerance

Patient Name: _____ Date: _____

Struggle Survey

Tell us about your struggles, whether they be pain related (headaches, back pain, neck pain, wrist/ankle pain, etc.) or functional (digestion, energy, ADD/ADHD, vertigo, sleep, etc.) you have been experiencing.

If you are truly here for wellness and haven't had any struggles in the last month please check this box. ☐

Struggle 1: _____

Severity:(no issue) ◯0 ◯1 ◯2 ◯3 ◯4 ◯5 ◯6 ◯7 ◯8 ◯9 ◯10 (big issue) Progression: ◯same ◯better ◯worse

Impact on life: ◯mild ◯mod ◯severe Frequency: ◯< 25% ◯25-50% ◯50-75% ◯>75%

When did you notice the problem? _____ How did it start?_____

Better with: ☐rest ☐motion ☐ice ☐heat ☐meds ☐topicals ☐massage ☐chiropractic ☐other: _____

Worse with: ☐bending ☐movement ☐lifting ☐walking ☐sit ☐stand ☐lying ☐stress ☐other: _____

Feels like? ☐sharp ☐shooting ☐dull ☐ache ☐burning ☐stiff ☐stabbing ☐throbbing ☐numb ☐sore

Does it travel? (to arms, legs, etc.) ◯Yes ◯No If yes, where? _____

What time of day is it worst? ☐morning ☐afternoon ☐evening ☐falling asleep ☐while sleeping

What treatment(s) have you received? ☐PT ☐surgery ☐injection ☐chiropractic ☐acupuncture Helpful? ◯Yes ◯No

Struggle 2: _____

Severity:(no issue) ◯0 ◯1 ◯2 ◯3 ◯4 ◯5 ◯6 ◯7 ◯8 ◯9 ◯10 (big issue) Progression: ◯same ◯better ◯worse

Impact on life: ◯mild ◯mod ◯severe Frequency: ◯< 25% ◯25-50% ◯50-75% ◯>75%

When did you notice the problem? _____ How did it start?_____

Better with: ☐rest ☐motion ☐ice ☐heat ☐meds ☐topicals ☐massage ☐chiropractic ☐other: _____

Worse with: ☐bending ☐movement ☐lifting ☐walking ☐sit ☐stand ☐lying ☐stress ☐other: _____

Feels like? ☐sharp ☐shooting ☐dull ☐ache ☐burning ☐stiff ☐stabbing ☐throbbing ☐numb ☐sore

Does it travel? (to arms, legs, etc.) ◯Yes ◯No If yes, where? _____

What time of day is it worst? ☐morning ☐afternoon ☐evening ☐falling asleep ☐while sleeping

What treatment(s) have you received? ☐PT ☐surgery ☐injection ☐chiropractic ☐acupuncture Helpful? ◯Yes ◯No

Struggle 3: _____

Severity:(no issue) ◯0 ◯1 ◯2 ◯3 ◯4 ◯5 ◯6 ◯7 ◯8 ◯9 ◯10 (big issue) Progression: ◯same ◯better ◯worse

Impact on life: ◯mild ◯mod ◯severe Frequency: ◯< 25% ◯25-50% ◯50-75% ◯>75%

When did you notice the problem? _____ How did it start?_____

Better with: ☐rest ☐motion ☐ice ☐heat ☐meds ☐topicals ☐massage ☐chiropractic ☐other: _____

Worse with: ☐bending ☐movement ☐lifting ☐walking ☐sit ☐stand ☐lying ☐stress ☐other: _____

Feels like? ☐sharp ☐shooting ☐dull ☐ache ☐burning ☐stiff ☐stabbing ☐throbbing ☐numb ☐sore

Does it travel? (to arms, legs, etc.) ◯Yes ◯No If yes, where? _____

What time of day is it worst? ☐morning ☐afternoon ☐evening ☐falling asleep ☐while sleeping

What treatment(s) have you received? ☐PT ☐surgery ☐injection ☐chiropractic ☐acupuncture Helpful? ◯Yes ◯No

**For additional struggles, please fill out another "Struggle Survey" form to submit or write on the back of this page.

Contact Information Changes

If any of your contact information has changed please provide the new information below.

Address: _____

Phone Number: _____ E-mail Address: _____

Contact Preference: ◯Phone ◯E-mail ◯Text Form delivery: ◯E-mail ◯Mail ◯In person

Any changes to your insurance information? ◯Yes ◯No If yes, please supply us with your new insurance card.

Terms of Acceptance

The goal of our office is to enable patient to gain control of their health. To attain this we believe communication is the key. There are often topics that are hard to understand and we hope this document will clarify those issues for you. Please read below and if you have any questions please feel free to ask one of our staff members.

INFORMED CONSENT

A patient, in coming to the chiropractic physician, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or care if she is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known, or to learn through healthcare procedures whatever he/she is suffering from a latent pathological defect, illnesses or deformities which would otherwise not come to the attention of the chiropractic physician. The chiropractor provides a specialized, non-duplicating health care service. Your doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regimen. I understand that if I am accepted as a patient by a chiropractor at Heartland Family chiropractic, I am authorizing them to proceed with any treatment that may be necessary. Furthermore, any risk involved regarding chiropractic treatment, will be explained to me upon my request. It is understood and agreed that the amount paid to the doctor for x-rays are for examination only and the x-ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient of this office.

LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS

I authorize the chiropractor to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such chiropractic care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the chiropractor or chiropractic group insurance benefits otherwise payable to me. I understand that my chiropractic insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my or my dependents behalf in full or according to insured contractual agreement. I authorize the chiropractor to release any information including the diagnosis and records of any treatment or examination rendered to me or my child during the period of such chiropractic care to third party payers and/or health practitioners. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

ACKNOWLEDGMENT

I have reviewed the notice of privacy practices (HIPPA) and have been provided an opportunity to discuss my right to privacy. Upon request I will be given a copy.

COMMUNICATION

May we leave messages on any answering device, i.e. home answering machines or voicemails? Yes No

MISSED APPOINTMENTS

There is a possible $25 fee charged for all appointments that are not cancelled prior to scheduled visit.

I, _____, have read and fully understand the above statements. I hereby attest that the information and health history I have provided is complete and accurate. I understand the importance of providing a truthful health history in order to assist the doctor in providing the best chiropractic care possible.

Print Name:_____

Signature:_____Date:_____

CONSENT TO TREAT A MINOR

Parent Signature:_____Date:_____