# Pediatric Patient Questionnaire

## CONFIDENTIAL PATIENT INFORMATION

Child's Name: Parent/Guardian Name(s):
Street Address: City, State, Postal Code:
Cell Phone: Other Phone: Child's Sex: ○ M ○ F
Email: Child's SS #: Birthdate: Age:
How did you hear about us? Weight: Height:
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 pregnacy:

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

Patient Name: ______________________ Date: ___/___/___

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**Please check ALL insurance coverage that may be applicable in this case:**

__ Major Medical __ Medicaid __ Medicare __ Worker's Compensation __ Auto Accident
__ Medical Savings Account & Flex Plans __ Other

**Primary Insurance:** ________________________________

**Secondary Insurance:** ________________________________

**AUTHORIZATION & RELEASE:** I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians, other health care providers, payors, and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information, we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

## INFORMED CONSENT FOR CHIROPRACTIC TREATMENT:

**BAKER FAMILY CHIROPRACTIC:** I hereby request and consent to the performance of chiropractic treatments (also known as chiropractic adjustments or chiropractic manipulative treatments) and any other associated procedures: physical examination, tests, diagnostic x-rays, physiotherapy, physical medicine, physical therapy procedures, etc. on me by the Doctor of Chiropractic named above and/or other assistants and/or licensed practitioners. I understand, as with any health care procedures, that there are certain complications, which may arise during chiropractic treatments. Those complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, Homer's syndrome, diaphragmatic paralysis, cervical myelopathy, costovertebral strains, and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to complications including stroke.

I do not expect the doctor to be able to anticipate all risks and complications, and I wish to rely upon the doctor to exercise judgement during the course of the procedure(s) which the doctor feels at the time, based upon then known, that are in my best interest. I have had an opportunity to discuss the nature, purpose and risks of the chiropractic treatments and other recommended procedures. I have had my questions answered to my satisfaction. I also understand that specific results are not guaranteed.

If there is any dispute about my care, I agree to a resolution by binding according to the American Arbitration Association guidelines. I have read or have read to me the above explanation of the chiropractic treatments. I state that I have been informed and weighted the risks involved in chiropractic treatment at this health care office. I have decided that it is my best interest to receive chiropractic treatment. I intend for this consent to cover the entire course of treatment for my present condition(s) and for any future condition(s) for which I seek treatment.

| ________________________ | ________________________ | ___/___/ 20___ |
|---|---|---|
| **Printed Name of Patient** | **Signature** | **Date** |
| ________________________ | ________________________ | ___/___/ 20___ |
| **Signature of Representative (if applicable)** | **Witnessed (Employee)** | **Date** |

**HIPAA Privacy Notice:** This notice describes how medical information about you may be used and disclosed, and how you can get access to this information. Please review it carefully. If you have any questions about this Notice, please contact our Privacy Officer, Dr. Kate Baker, or any staff member in our office. This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out your treatment, collect payment for your care and manage the operations of this clinic. It also describes our policies concerning the use and disclosure of this information for other purposes that are permitted or required by law. It describes your rights to access and control your protected health information. "Protected Health Information" (PHI) is information about you, including demographic information that may identify you, that relates to your past, present, or future physical or mental health or condition and related health care services. We are required by federal law to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice at any time. The new notice will be effective for all protected health information that we maintain at that time. You may obtain revisions to our Notice of Privacy Practices by accessing our website, www.bakerfamilychiroky.com, calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment. A copy of our Notice is readily available to you in our office at any time. At this time, you will be offered a full copy of our Notice. Please sign below that you have been made aware and would like to receive a copy or that you have been made aware of and are declining a copy at this time.

☐ **Request Copy**
☐ **Decline Copy**

| ________________________ | ___/____/ 20___ |
|---|---|
| **Signature** | **Date** |

# PATIENT INFORMATION ACCESS CONSENT

☐ I, ______________________________ **(print name)**, give the staff of Baker Family Chiropractic permission to discuss the selected content with the person/people listed below. If I decide to change this permission for any reason, for any person listed below, I acknowledge that it will be my responsibility to make the staff aware of the changes I wish to make to my consent. This consent will remain in effect unless I notify the staff of Baker Family Chiropractic.

☐ I, ______________________________ **(print name)** *DO NOT* give the staff of Baker Family Chiropractic permission to discuss the content of my appointments, financial information, or medical care with anyone else at this time.

**Patient Signature** ________________________________________ **Date** ______________

| ______________________ | ______________________ | ______________________ |
|---|---|---|
| (Print Name) | (Relationship) | (Phone Number) |

1. Make/change appointments Yes _____ No _____
2. Discuss financials Yes _____ No _____
3. Discuss medical care Yes _____ No _____

| ______________________ | ______________________ | ______________________ |
|---|---|---|
| (Print Name) | (Relationship) | (Phone Number) |

1. Make/change appointments Yes _____ No _____
2. Discuss financials Yes _____ No _____
3. Discuss medical care Yes _____ No _____

| ______________________ | ______________________ | ______________________ |
|---|---|---|
| (Print Name) | (Relationship) | (Phone Number) |

1. Make/change appointments Yes _____ No _____
2. Discuss financials Yes _____ No _____
3. Discuss medical care Yes _____ No _____