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:

Email: | Child's SSN: | Birthdate: | Age:

How did you hear about us? | Height: | Weight:

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 or 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? ○ 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?

○ Resolve existing condition
○ Overall wellness
○ Both

Has your child ever visited a chiropractor? ○ Yes ○ No – If yes, what is their name:

– What is their specialty: ○ Pain Relief ○ Physical Therapy & Rehab ○ Nutrition ○ 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 often? _____

Did mother drink? ○ Yes ○ No If yes, how often? _____

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 noticable 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 weeks was your child born?

Where was your child born? – Who delivered your baby?

Please indicate 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 min.:

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 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 vaccine 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 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

Parent/Guardian Signature: _____ Date: _____

Northwoods Family Chiropractic
202 W Adams Street
Iron River, MI 49935
906-265-9000

Informed Consent

Medical doctors, chiropractic doctors and osteopaths who perform manipulation are required by law to obtain your informed consent before starting treatment.

I, _____ on _____ do hereby give my consent to the performance of conservative noninvasive treatment to the joints and soft tissues. I understand that the procedures may consist of manipulations/adjustments and/or massage therapy involving movement of the joints and soft tissues. Physiotherapy and exercises may also be used.

Although spinal manipulation/adjustment and/or massage therapy is considered to be one of the safest, most effective forms of therapy for muscular skeletal problems, I am aware that there are possible risks and complications associated with these procedures as follows:

Soreness: I am aware that, like exercise, it is common to experience muscle soreness in the first few treatments.

Dizziness: Temporary symptoms like dizziness and nausea can occur but are relatively rare.

Fracture/Joint Injury: I further understand that in isolated cases underlying physical defects, deformities, or pathologies like weak bones from osteoporosis may render the patient susceptible to injury. When osteoporosis, degenerative disk, or other abnormality is detected, this clinic will proceed with caution.

Stroke: Although strokes happen with some frequency in our world, strokes from chiropractic adjustments are rare. I am aware that nerve or brain damage including stroke is reported to occur once in one million to once in ten million treatments. Once in a million is about the same chance as getting hit by lightening. Once in ten million is about the same chance as a normal dose of aspirin or Tylenol causing death.

Tests have been performed on me to minimize the risk of any complication from treatment and I freely assume these risks.

Treatment Results

I also understand that there are beneficial effects associated with these treatment procedures including decreased pain, improved mobility and function, and reduced muscle spasm. However, I appreciate there is no certainty that I will achieve these benefits.

I realize that the practice of medicine, including chiropractic, is not an exact science and I acknowledge that no guarantee has been made to me regarding the outcome of these procedures.

I agree to the performance of these procedures by my doctor and such other persons of the doctor's choosing.

Alternative Treatments Available

Reasonable alternative to these procedures have been explained to me including rest, home applications of therapy, prescription or over-the counter medications, exercises and possible surgery.

Medications: Medication can be used to reduce pain or inflammation. I am aware tat long-term use or overuse of medication is always a cause for concern. Drugs may mask pathology, produce inadequate or short-term relief, undesirable side-effects, physical or psychological dependence, and may have to be continued indefinitely. Some medications may involve serious risks.

Rest/Exercise: It has been explained to me that simple rest is not likely to reverse pathology, although it may temporarily reduce inflammation and pain. The same is true of ice, heat, or other home therapy. Prolonged bedrest contributes to weakened bones and join stiffness. Exercises are of limited value but are not corrective of injured nerve and joint tissues.

Surgery: Surgery may be necessary for joint stability or serious disk rupture. Surgical risks may include unsuccessful outcome, complications, pain or reaction to anesthesia, and prolonged recovery.

No treatment: I understand the potential risk of refusing or neglecting care may include increase pain, scar/adhesion, formation, restricted motion, possible nerve damage, increased inflammation, and worsening pathology, The aforementioned may complicate treatment making future recovery and rehabilitation more difficult and lengthier.

I have read or have had read to me the above explanation of chiropractic treatment. Any questions I have had regarding these procedures have been answered to my satisfaction PRIOR TO MY SIGNING THIS CONSENT FORM. I have made my decision voluntarily and freely. To attest to my consent to these procedures, I herby affix my signature to this authorization for treatment.

_____ Signature of patient/guardian

_____ Signature of witness

_____ Date and time

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have reviewed the Notice of Privacy Practices of Northwoods Family Chiropractic (Please initial one of the following options and sign below.)

I acknowledge that I have read the Notice of Privacy Practices from Northwoods Family Chiropractic prior to signing this document. Northwoods Family Chiropractic Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of the bills, or the performance of health care operations of Northwoods Family Chiropractic. The Notice of Privacy Practices for Northwoods Family Chiropractic is also provided on request at the main administration desk of the practice. This Notice also describes my rights and Northwoods Family Chiropractic's duties with respect to my health information.

Northwoods Family Chiropractic reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the clinic and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____ I wish to receive a paper copy of Privacy Notice.

_____ I do not request a copy of the Privacy Notice at this time. I acknowledge that I can request a copy at any time and the Privacy Notice is posted in the office. If I should have a problem or question in regard to my rights, I may speak with the Privacy Officer about my concerns.

X_____ _____

Signature of Patient/Guardian Date

X_____ _____

Witness (Office Staff) Date

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I,_____

DOB_____authorize_____

to release the following medical information to Northwoods Family Chiropractic any and all medical records including imaging and reports, i.e. x-rays, MRI, CT, etc.

Please send films to the following address:

Northwoods Family Chiropractic, P.C.
202 W. Adams St.
Iron River, MI 49935

Northwoods Family Chiropractic, P.C.
337 Superior Avenue
Crystal Falls, MI 49920

Please fax records to the following phone number:

Northwoods Family Chiropractic (Iron River)
(906) 265-9009

Northwoods Family Chiropractic (Crystal Falls)
(906) 874-0112

This information is being released for diagnostic and treatment purposes only and may not be used for any other purpose or released to any other person(s) without my written consent.

This release is effective until it is revoked by me at any time by providing notice in writing to the above-named party.

_____ Date: _____
Patient

_____ Date: _____
Parent/Guardian

_____
Witness

Financial Policy

Insurance Coverage

Welcome to Northwoods Family Chiropractic. Your insurance policy is an agreement between you and your insurer, not between your insurer and this clinic. Like all types of care, coverage for chiropractic services varies from insurer to insurer and plan to plan. Most insurance policies require the beneficiary to pay co-insurance, co-payment and/or a deductible. For example: if you have a deductible of $100, and your insurance pays 80%, you are responsible for 20% of all charges incurred during the year after you have paid your $100 at the beginning of the year. Our clinic will call your insurer to verify your benefits, however, we are not responsible for your insurer's final payment and benefit determinations.

Payments

In order to help you determine your responsibility toward payment for services, please read the following, and initial your preference for the method of payment of your account. Please notify this office if the status of your insurance changes.

Private Pay: (please initial)

A_____ As I have no insurance, I agree to assume all responsibility and to keep my account current by paying for services when they are rendered.

B_____ I have insurance, but I wish to file my claims personally, and I agree to assume all responsibility and to keep my account current by paying for each visit at the time services are rendered.

Health Insurance: (please initial)

C_____I would like this clinic to bill my insurance. I understand I am responsible for the costs of treatment.

Returned Check/Insufficient Funds Policy

It is the policy of Northwoods Family Chiropractic to assess a $20.00 returned check/insufficient funds fee to patients who have a returned check due to insufficient funds/other reasons or insufficient funds when running a stored credit card on file. More than 2 repeat occurrences will result in the inability to pay in this manner.

_____ My initials here indicate that I understand the above returned check policy.

I understand that all health services rendered to me and charged to me are my personal financial responsibility. I understand and agree to the conditions of this policy.

_____ _____

Signature Date

Northwoods Family Chiropractic
202 W Adams St
Iron River, MI 49935
906-265-9000

CONSENT TO TREAT A MINOR

I, the undersigned parent and/ or guardian of _____,

Date of Birth _____/_____/_____, S.S. # _____-_____-_____,

a minor child, do hereby authorize this office and its doctors to administer chiropractic care to my child, as they deem necessary, with out parental supervision.

_____
Parent or legal guardian name (please print)

_____
Parent or legal guardian's signature

_____
Witness's signature

_____/_____/_____
Date (effective on file or unless revoked earlier in writing)

Agreement for Payment of Services

By signing the authorization above I affirm that I understand and agree that:

- Health and accident insurance polices are and agreement between patients and their insurance carriers;
- This office will prepare any necessary reports and forms to assist me in making collection from the insurance company
- Any amount that is authorized to be paid directly to this office will be credited to my account upon receipt, I permit this office to endorse insurance payments to be applied to my account;
- All services rendered to me are charged directly to me and that I am personally responsible for the payment of my account
- It is the policy of this chiropractic office to collect for services as they are rendered, unless other financial arrangements are made with our billing specialist.

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Signature Date

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_____ Date: _____
Patient

_____ Date: _____
Parent/Guardian

_____
Witness