Bridger Chiropractic Clinic

Dr. Jeff Feenstra, Dr. Ellen Purser & Dr. Michael Jones
517 S. 22nd Avenue, Suite 7
Bozeman, MT 59718
(406) 587-9122 www.bridgerchiropractic.com fax: (406) 587-9287

Initial Child & Adolescent Questionnaire

Your Name: _____ Your Mom: _____

Your Dad: _____

Mainly for Moms:

1. Tell us about your pregnancy

Did you carry to full term? _____

Any major stress during pregnancy? _____

Describe any complications and when they occurred: _____

_____

2. Tell us about your delivery and birth of this child:

Midwife? _____ Obstetrician? _____ Birthing Center? _____ Hospital? _____ Home? _____

Did you have a C-section? _____ Were forceps used? _____ Vacuum Extraction? _____

Were you induced? _____ (_____ Pitocin _____ Cervadil) Did you have an Epidural? _____

Was it a difficult birth? _____ Length of labor? _____ Was excessive force used? _____

Did you tear? _____ Did you have an episiotomy? _____ Baby's position abnormal? _____

What was the baby's **APGAR** score at birth? _____ At 5 minutes? _____

3. Tell us more:

Did you breastfeed, and how soon after birth? _____ Until what age? _____

What formula after? _____ What food was introduced first? _____

Did you consume alcohol during your pregnancy? _____ How much? _____

Did you smoke? _____ How much? _____ How long? _____

Did you take any medication during your pregnancy? _____

For what? _____ What type? _____

Any exposures to ultrasound? _____ How many? _____ Amniocentesis? _____

4. As a baby/toddler (birth to 4 years), did any of the following occur?

_____ Fall from a changing table
_____ Tumble down stairs
_____ Fall out of crib
_____ Involved in car accident
_____ Fall off playground equipment
_____ Play in a Jolly Jumper
_____ Frequent ear infections
_____ Tonsillitis
_____ Reaction to vaccination
_____ Nosebleeds
_____ Problems feeding
_____ Frequent crying spells
_____ Frequent fevers
_____ Frequent bouts of diarrhea
_____ Constipation
_____ Sleeping problems
_____ Frequent colds
_____ Colic
_____ Did not gain weight
_____ Allergies
_____ Skin problems
_____ Other _____

Please explain the above: _____

_____

_____

5. As a young child (5-12 years), did any of the following occur?

_____ Fall from a tree
_____ Fall off a bicycle
_____ Fall off playground equipment
_____ Sports accident
_____ Car accident
_____ Stomach pains
_____ Scoliosis
_____ Bed wetting
_____ Hyperactivity/Autism
_____ Learning difficulties
_____ Asthma
_____ Allergies
_____ Leg/knee pains
_____ Other _____

Please explain the above: _____

_____

_____

6. Tell us about any vaccinations your child has had: _____

_____

_____

Any reactions to any of these? _____

_____

Were you told that you had a choice in vaccinating your child? _____ **YES** _____ **NO**
Would you like information on the other side of this issue? _____ **YES** _____ **NO**

7. As a child or adolescent, has your child experienced any of the following?

_____ Headaches
_____ Dizziness
_____ Ringing in ears
_____ Asthma
_____ Hyperactivity
_____ Fatigue
_____ Numbness in arms/hands
_____ Arm/wrist pains
_____ Sleeping problems
_____ Allergies
_____ Stomach problems
_____ Weight gain/loss
_____ Foot/ankle/knee pains
_____ Tingling in arms/legs
_____ Neck/back pains
_____ Shoulder pains
_____ Growing pains
_____ Other _____

Please explain any of the above: _____

_____

8. **Which of the problems you have checked off is the worst?** _____

_____

Is this problem: Constant _____ Intermittent _____ Occasional _____ Cyclic _____

9. **How long has it persisted?** _____

10. **When it is at its worst, how does it make your child feel?** _____

11. **What have you done about it that has NOT worked?** _____

_____

_____

12. **What makes it worse?** _____

13. **What effect does this problem have on your child's body functions?** _____

_____

_____

14. **Describe any hospital stays:** _____

_____

15. **Approximately how many times have antibiotics been prescribed and for what conditions?** _____

_____

_____

16. **List any medications your child is currently taking:** _____

_____

17. **To summarize, what is your purpose for this appointment?** _____

_____

18. **Is there anything else you feel we should know?** _____

_____

_____

_____

Signature of parent or guardian: _____

Date: _____

Thank You!

Bridger Chiropractic Clinic

Dr. Jeff Feenstra, Dr. Ellen Purser & Dr. Michael Jones
517 S. 22nd Avenue, Suite 7
Bozeman, MT 59718
(406) 587-9122 www.bridgerchiropractic.com fax: (406) 587-9287

** Financial Policy **

I understand and agree that the final responsibility for payment for the care I receive at Bridger Chiropractic Clinic is mine. I understand that if I do not have insurance that covers Chiropractic, I need to pay in full for services rendered at the time of service. I understand that if I do have insurance, it is an arrangement between myself and my insurance company, NOT between Bridger Chiropractic and my insurance company. If I suspend or terminate my care at Bridger Chiropractic, I understand that any fees I incurred will be due and payable immediately. In the case of collections or litigation, I agree to pay for all fees incurred in the event of any action of the kind.

_____

Signature (this will also indicate that you have received our complete Financial Policy handout)

_____

Date

** 24-Hour Cancellation Policy **

A charge will be made for broken appointments unless a 24-hour notice is given. Your appointment time is reserved specifically for you. It is important that you keep your appointment so you receive your treatment. If you are unable to keep your appointment, and as a courtesy to others, 24 hour notice is required so that we may schedule another patient who may need care.

_____ _____

Signature Date

The Federal Government requires that we ask you the following questions:

Race *(check one)*

❑ White ❑ Black/African American ❑ Hispanic ❑ American Indian/Alaskan Native
❑ Asian ❑ Asian Indian ❑ Chinese ❑ Filipino
❑ Japanese ❑ Korean ❑ Vietnamese ❑ Native Hawaiian or other Pacific Island
❑Samoan ❑ Guamanian or Chamorro ❑Other_____ ❑ I choose not to specify

Multi-Racial *(check one)* ❑Yes ❑No ❑ Unknown

Ethnicity *(check one)* ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ I choose not to specify

Preferred Language *(check one)*

❑ English ❑ Spanish ❑ American Sign Language ❑ Chinese ❑ French ❑ German
❑ Tagalog ❑ Vietnamese ❑ Italian ❑ Korean ❑ Russian ❑ Polish
❑ Arabic ❑ Portuguese ❑ Japanese ❑ French Creole ❑ Greek ❑ Hindi
❑ Persian ❑ Urdu ❑ Gujarati ❑ Armenian ❑ I choose not to specify

Verification Question *(choose only one question by circling the question, then give the answer to that question)*

❑ What is the name of your favorite pet? ❑ In what city were you born? ❑ What high school did you attend?
❑ What is your favorite movie? ❑ What is your mother's maiden name? ❑ On what street did you grow up?
❑ What was the make of your first car? ❑ When is your anniversary? ❑ What is your favorite color?

Verification Answer to the Chosen question: _____

Do you currently smoke tobacco of any kind? ❑ Yes ❑ Former smoker ❑ Never been a smoker

If yes, how often do you smoke: ❑ Current every day smoker ❑ Current sometimes smoker

If yes, what is your level of interest in quitting smoking?

❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10
No interest *Very Interested*

Has any doctor diagnosed you with Hypertension presently? ❑ Yes ❑ No If yes, describe: _____

_____

Has any doctor diagnosed you with Diabetes presently? ❑ Yes ❑ No If yes, what kind? ❑ Type I ❑ Type II

If yes to Diabetes, was your blood lab-work test for hemoglobin A1c > 9.0%? ❑ Yes ❑ No ❑ Not Sure

If yes, other comments regarding Diabetes: _____

Bridger Chiropractic Clinic

Dr. Ellen Purser & Dr. Michael Jones
517 S. 22nd Avenue, Suite 7
Bozeman, MT 59718
(406) 587-9122 www.bridgerchiro.com fax: (406) 587-9287

I hereby acknowledge that I have had the opportunity to read and obtain a copy of the Health Insurance Portability and Accountability Act (HIPAA) Privacy rule for Bridger Chiropractic Clinic ***

Patient/Guardian Signature: _____ date:_____
Print Patient Name: _____
Relationship to patient: Self Parent Guardian Responsible Party Legal Representative, etc._____

*** This information is found under the "New Patient Forms" tab as "HIPPA info"

Authorization To Disclose Health Information

As a patient of Bridger Chiropractic Clinic you are protected under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). We may disclose your health information to a family member, friend or other person to the extent necessary to help with your health care or with payment of your health care, but only if you agree that we may do so.

I authorize _____to inquire about:
(print name of parent, significant other, spouse, family member, etc.)

___ Payments/Charges
___ Health Information (prescriptions, test results etc.)
___ Consult with my Doctor regarding my health care

Patient Signature: _____date: _____

Insurance Authorization

I hereby authorize Bridger Chiropractic Clinic to furnish information to my insurance carriers concerning my diagnosis and treatments. I also authorize payments of insurance benefits to be made directly to Bridger Chiropractic Clinic. I understand that I am responsible for all charges incurred.

Patient/Guardian Signature: _____date_____
Print Patient Name: _____
Relationship to Patient: Self, Parent, Guardian, Responsible Party, Legal Representative, Etc. _____