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:

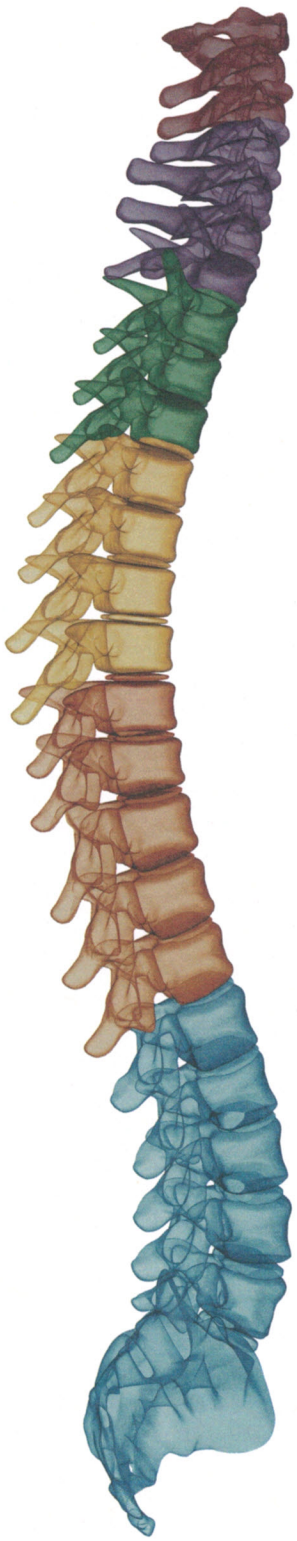
Please explain any notable episodes of mental or physical stress during your pregnancy:

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

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
		☐	☐ Crohn'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: / /

Structure Integrative Healthcare Financial Policy

Please initial for every statement below to indicate you understand our financial policy.

1. I understand that I am financially responsible for all charges whether or not they are paid by insurance.
   _____

2. I understand that I am responsible for all co-pays, deductibles and co-insurance amounts per my contract with my insurance company.
   _____

3. I understand that it is my responsibility to respond to any requests for information that the insurance company may make of me in order for them to pay my insurance claim. If I do not respond to their requests in a timely manner I understand that I will be charged in full for all services rendered.
   _____

4. I understand that any outstanding balances past 120 days may be put in collections. If my account is put in collections I understand that not only will I owe the collectible amount, I will also be responsible for all costs and fees associated with the collections process.
   _____

5. I understand that returned checks will be subject to additional fees.

   _____

6. I understand that if I need to cancel or reschedule an appointment, I must notify the office at least 24 hours in advance. If I fail to notify the office, I will be charged a cancellation fee.
   _____

I certify that I, and/or my dependent (s) have insurance coverage with
_____ (name of insurance)
and assign directly to Structure Integrative Healthcare all insurance benefits. I understand I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. Structure Integrative Healthcare may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

_____ (signature and date)

_____ (print name)

Primary Insurance Company Name _____
Member Number /Claim _____
Group Number _____
(copies of both sides of the insurance card must be included in the patient file)

Secondary Insurance Company Name _____
Member Number /Claim _____
Group Number _____
(copies of both sides of the insurance card must be included in the patient file)

HIPPA Notice of Privacy Practices

Structure Integrative Healthcare
932 N. Wright St. Suite 152 Naperville, IL 60563
(630) 447-0123

For use and/or disclosure of Protected Health Information (PHI) in order to carry out treatment, payment, and healthcare operations at Structure Integrative Healthcare (SIH).

I hereby state that by signing this Consent I acknowledge and agree as follows:

1. The Practice's (SIH's) Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my Protected Health Information (PHI), which are necessary for SIH to provide treatment to me, to obtain payment for that treatment, and to carry out its health care operations. SIH explained to me that the Privacy Notice would be available to me in the future at my request. SIH has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice prior to signing this Consent. SIH reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.
SIH's Notice of Privacy Practices can be provided if asked for at the front desk. I may also request a copy from this office at any time to be sent by US Mail.
This Notice of Privacy Practices includes a description of my rights and the duties of SIH with respect to my protected health information.

I have read and understand the above notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

Name (printed): _____

Signature: _____ Date: _____

Office Use Only

We have made the following attempt to obtain the patients signature acknowledging receipt of the Notice of Privacy Practice.

Date: _____ Attempt: _____
Staff Name: _____

STRUCTURE integrative HEALTHCARE
chiropractic / acupuncture

Informed Consent for Chiropractic Care

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks and alternatives.

Chiropractic is a science and art which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may effect the restoration and preservation of health. Health is a state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity. One disturbance to the nervous system is called a vertebral subluxation. This occurs when one or more of the 24 vertebrae in the spinal column become misaligned and/or do not move properly. This causes alteration of nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by an adjustment. An adjustment is the specific application of forces to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine. Adjustments are usually done by hand but may be performed by handheld instruments. In addition, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be included.

If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risks and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

_____ _____ _____
Print Name Signature Date

Consent to evaluate and adjust a minor child:

I, _____ being the parent or legal guardian of _____ have read and fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care.

Pregnancy Release:

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Date of last menstrual cycle: _____

_____ _____
Signature Date

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: _____