Radiant Health Chiropractic
Tammy Amoth, D.C.
534 Water Street
Eau Claire, WI 54703
715.838.9432

PEDIATRIC HEALTH QUESTIONAIRE

Please take a moment to answer the following questions that are designed to maximize your child's health. Many types of stresses (physical, mental, chemical) can interfere with your child's growing spine and nervous system. Spinal health is an exciting new concept for many people, so please remember to ask questions.

Name _____ Date _____

Address _____

Guardian Information: Name _____
Home Phone (__)_____ Work Phone (__) _____
Cell Phone (__) _____ E-mail _____

Birth Date _____ Age _____ Social Security# _____

Do you have insurance that covers Chiropractice care? Yes __ No__ Medicare coverage Yes __ No __

Name of person financially responsible for this account _____

Name of Insurance Company _____ Policy/Group# _____

Subscriber's name _____ Relationship to patient _____

Subscriber's Birth Date _____ Subscriber's Social Security # _____
COPY OF YOUR INSURANCE CARD IS NEEDED.

Reason for visit to our office: _____
_____
_____
_____
_____

CIRCLE APPROPRIATELY:
Birth Place: Home Hospital Birth Center
Delivered by: Midwife OB/GYN
Type of Birth: Vaginal C-section
Procedures: Forceps Vacuum Extraction Epidural
Delivery Complications: _____
Ultrasound during Pregnancy? Yes No If yes, how many? _____

Is/Was your child breast fed? Yes No If yes, how long?_____
Intolerance/allergy to formula or foods? Yes No If yes, what? _____
Does your child take supplements? Yes No

Did your child reach developmental milestones such as crawling, walking and talking at appropriate ages? Yes No

According to the National Safety Council, approximately 50% of infants fall head first from a high place (bed, couch, changing table) during the first year of life.
Has this happened to your child? Yes No

Has your child been involved in a motor vehicle accident of any kind? Yes No
Has your child had surgery? Yes No If yes, for what? _____
Has your child been seen by either a doctor or a hospital on an emergency basis?
_____
Does your child have any learning challenges? Yes No If yes, what are they?
_____

What sports does your child participate in? Soccer Football Gymnastics Dance Karate Hockey Baseball Volleyball Basketball Swimming Other:_____

Does your child carry a backpack? Yes No

Circle any of the following your child has had in the past 12 months:

Ear Infection	Scoliosis	Seizures	Chronic cold
Asthma	Allergies	ADD	ADHD
Diabetes	Headaches	Bed Wetting	Back discomfort
Eczema	Digestive Problems	Recurring fevers	Colic
Psoriasis	Growing pains	Temper Tantrums	Visual Impairment
Hearing difficulty	Mood Swings		

Approximately how many prescriptions of antibiotics has your child taken?
During the past 12 months: _____ During his/her lifetime?_____

Approximately how many other prescription medications has your child taken?
During the past 12 months: _____ During his/her lifetime? _____
Reason for prescriptions:_____

How many over the counter medications has your child taken? (ex: Tylenol, Ibuprofen)
During the past 12 months: _____ During his/her lifetime? _____
Types:_____

Is your child currently taking **any** medications? Yes No
If yes, what? _____

Vaccinations: After careful consideration of the literature and facts, some parents choose not to have their child vaccinated.
Has your child been vaccinated? Yes No
If yes, what age was their first vaccination given? _____
If you vaccinate, are they current? Yes No
Has your child ever had a reaction of **any** kind to a vaccination? Yes No
If yes, what type of reaction? (fever, rash, sleeplessness): _____

Are you interested and committed to safeguarding your child's health? Yes No

WHO MAY WE THANK FOR REFERRING YOU? _____

I authorize the doctors at Radiant Health Chiropractic to examine and care for my child.

Signed: _____ Date: _____
(Parent or Guardian)

PATIENT HEALTH INFORMATION CONSENT FORM

Radiant Health Chiropractic
534 Water St. Eau Claire, WI 54703

Our Privacy Pledge

We are very concerned with protecting your privacy. While the law requires us to give you a copy of our *Privacy Notice,* please understand that we have and always will respect the privacy of your health information. At your request, we will give you a copy of our complete *Privacy Notice.* Radiant Health Chiropractic does reserve the right to change our privacy practices as described in this notice. If any future changes are made to our privacy practices, we will notify you in writing.

Consent for Use or Disclosure of Health Information

The following are possible circumstances in which we may have to use or disclose your PHI (Patient Health Information):

- We may have to disclose your PHI to another health care provider or hospital if it is necessary to refer you to them for diagnosis assessment or treatment of your health condition.
- We may have to disclose your PHI and billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your PHI within our office for quality control or other operational purposes.

Initials:_____

Appointment Reminders and Health Care Information Authorization

Authorized staff of Radiant Health may need to use your name, address, phone number, billing information and your clinical records to contact you with appointment reminders, information about treatment alternatives or other PHI. If this contact is made by phone and you are not home, a message will be left on your answering machine or voice mail. By signing this form you are giving us authorization to contact you in this manner. As well, you may restrict the individuals or organizations to which your PHI is released or you may revoke your authorization to us at any time; however, your revocation must be in writing and mailed to our office. We will not be able to honor your revocation request if we have already released your PHI before we receive your request to revoke your authorization. In addition, your authorization to give us your PHI allows us to disclose that information to your insurance company for benefit verification or claims processing. You have the right to refuse to give us this authorization. If you do not give us authorization, it will not affect the treatment we provide to you but it may affect reimbursement by your insurance company.

Permission to call you at work: Yes ___ No ___ Initials:_____

Wisconsin Chiropractic Association Authorization (WCA)

Authorized staff of Radiant Health may also need to disclose your name, address, phone number, billing information and your clinical records to the WCA. Due to possible problems with improper insurance claims processing or for assistance in receiving reimbursement for our services to you, your PHI may need to be disclosed to the WCA with your authorization. By signing this form, you are giving us authorization to send the WCA your PHI. You are also giving the WCA authorization to re-disclose your information to the party responsible for the payment of your services, the WCA's legal counsel, and state or federal agencies that may be asked to intercede on your behalf. You may restrict the individuals or organization to which your PHI is released or revoke your authorization to us at any time; however, your revocation must be in writing and mailed to our office. We will not be able to honor your revocation request if we have already released your PHI before we receive your request to revoke your authorization. You have the right to refuse to give us this authorization. If you do not give us authorization it will not affect the treatment we provide or the methods we use to obtain reimbursement for your care.

Initials:_____

Marketing Authorization

From time to time our office may mail you information to make you aware of special offers related to products, services and events that may interest you. Your authorization is required to provide the following products and/or services to you: birthday cards, congratulation cards, food drives, newsletters, coupons, coupon books, brochures, surveys, etc.

Initials:_____

Information that we use or disclose based on the authorization you are giving us may be subject to re-disclosure by the person who receives the information and may no longer be protected by the federal privacy rules. This notice is effective as of _____ and will expire seven years after the date on which you last received services from us

Initials_____

I authorize you to use or disclose my health information in the manner described above. I have read this consent form and also agree I am acknowledging that I have received a copy of this consent form.

_____

Patient Name (Signature) Patient Name (Printed) Date

_____

Authorized Provider Representative (Signature) Date

I refuse a copy of this form at this time. Initials _____