Office Use: Time _____

turning point chiropractic

New Pediatric Patient Questionnaire

Child's Full Name: _____ ◯ Male ◯ Female DOB: _____/_____/_____ Age_____

Address: _____ City, State, Zip:_____

Height:_____ Weight: _____ Parent(s)/Guardian(s) Name: _____

Parent Cell Phone: _____ Home phone: _____ Work Phone: _____

Best number to call? ◯ Cell ◯ Home ◯ Work Parent Email: _____

Other Children in the home's Names & Ages: _____

How did you hear about us? _____

Is your child receiving care from other health professionals? ◯ Yes ◯ No Name & specialty: _____

Who is your family's primary care physician? _____

On a scale from 1-10 (10 being the most), how committed are you to restoring your child's health? _____

Reason for this visit

Describe the health condition(s) that prompted this visit:_____

What impact has this had on your child's life? _____

When did this condition first begin? _____ How did this condition start? _____

Is this appointment related to ANY type of accident? ◯ Yes ◯ No

Is this condition: ◯ Getting worse ◯ Improving ◯ Intermittent ◯ Constant ◯ Unsure

What makes this condition worse? _____ What makes it better? _____

Has your child seen anyone else for this concern? ◯ Yes ◯ No Type of treatment: _____

Chiropractic Experience

Has your child ever visited a chiropractor before? ◯ Yes ◯ No

If yes, what was the reason for those visits? _____ When was your last visit? _____

Pregnancy

Did mom smoke during pregnancy? ◯ Yes ◯ No Did mom drink alcohol during pregnancy? ◯ Yes ◯ No Smokers at home? ◯ Yes ◯ No

Any illnesses of mom during pregnancy? ◯ Yes ◯ No If yes, please explain: _____

List any drugs/medications (including over the counter) taken during pregnancy: _____

List any supplements/vitamins taken during pregnancy: _____

Birth History

Child's birth was: ◯ At home ◯ Birth Center ◯ Hospital My OB/midwife/physician was: _____

Child's birth was: ◯ Vaginal ◯ C-section If C-section, was it: ◯ Scheduled ◯ Emergency

If vaginal, please indicate any methods of assistance used: ◯ Pain medication ◯ Epidural ◯ Forceps ◯ Vacuum extraction ◯ Episiotomy

Was child born: ◯ Cephalic (head first) ◯ Breech (feet first)

TPC Team Initial_____

Were there any complications? ◯ Yes ◯ No If yes, please explain: _____

Child's birth weight: _____ Child's birth height: _____ Gestational age at birth (weeks): _____

What was the duration of labor and birth? _____ hours APGAR score at birth: _____/10 After 5 minutes: _____/10

Growth & Development

Was the infant alert and responsive within 12 hours of delivery? ◯ Yes ◯ No If no, please explain: _____

Is/was your child breastfed? ◯ Yes ◯ No If yes, for how long? _____ Was your child formula fed? ◯ Yes ◯ No

Did/Does your child ever suffer from colic/reflux, or constipation as an infant? ◯ Yes ◯ No

Does your child have regular bowel/bladder movements? ◯ Yes ◯ No Does your child get sick often? ◯ Yes ◯ No

Does your child arch their neck/back, bang their head or feel stiff on a frequent basis? Yes ◯ No If yes, explain: _____

At what age did your child: Respond to Sound _____ Hold their head up _____ Follow an object _____ Vocalize _____ Teethe ____

Sit alone _____ Crawl _____ Walk _____ Begin cow's milk _____ Solid foods ____

Healthy History

Has child received any vaccinations? ◯ No ◯ Yes, on schedule ◯ Yes, delayed/selective schedule List any reactions: _____

Has child taken any antibiotics? ◯ Yes ◯ No If yes, how many times and list reason: _____

Any night terrors, sleepwalking, or difficulty sleeping? ◯ Yes ◯ No If yes, please explain: _____

Please list all hospitalizations as well as surgical history (please include year): _____

_____

Please list any major injuries, accidents, falls and/or fractures your child has sustained in his/her lifetime: _____

_____

Often seemingly unrelated symptoms can manifest as other health concerns. Please note if your child has had any of the following:

◯ Headaches	◯ Stomach Aches	◯ Asthma	◯ Walking Trouble
◯ Dizziness	◯ Diarrhea	◯ Sleeping Problems	◯ Fall off skateboard/skates
◯ Fainting	◯ Arm Problems	◯ Hypertension	◯ Fall from high chair
◯ Seizures/Convulsions	◯ Leg Problems	◯ Ruptures/Hernia	◯ Fall off bicycle
◯ Heart Trouble	◯ Joint Problems	◯ Anemia	◯ Fall in baby walker
◯ Chronic Earaches	◯ Backaches	◯ Autism Spectrum Disorder	◯ Fall off playground equipment
◯ Sinus Trouble	◯ Poor Posture	◯ Behavioral Problems	◯ Fall from changing table
◯ Scoliosis	◯ Orthopedic Problems	◯ ADD/ADHD	◯ Fall from crib, bed, couch
◯ Bed Wetting	◯ Muscle Pain	◯ Poor Appetite	◯ Fall down stairs
◯ Digestive Disorders	◯ Growing Pains	◯ Broken Bones	◯ Allergies, to: _____

I have read/understand the included information and certify it to be true and accurate to the best of my knowledge.

_____ _____

Parent/Guardian Signature Date Completed

TPC Team Initial_____

Patient Name: _____ Date: _____

QUADRUPLE VISUAL ANALOGUE SCALE (QVAS)

INSTRUCTIONS: Please circle the number that best describes the question asked.

NOTE: If you have more than one complaint, please answer each question for each individual complaint and indicate the score of each complaint.

EXAMPLE:

	Headache				Neck				Low back		
No pain											Worst possible pain
0	1	(2)	3	4	(5)	6	7	(8)	9	10	

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1. How would you rate your pain RIGHT NOW?

No pain											Worst possible pain
0	1	2	3	4	5	6	7	8	9	10	

2. What is your TYPICAL or AVERAGE pain?

No pain											Worst possible pain
0	1	2	3	4	5	6	7	8	9	10	

3. What is your pain level AT ITS BEST? (How close to 0 does your pain get at its best?)

No pain											Worst possible pain
0	1	2	3	4	5	6	7	8	9	10	

4. What is your pain level AT ITS WORST? (How close to 10 does your pain get at its worst?)

No pain											Worst possible pain
0	1	2	3	4	5	6	7	8	9	10	

OTHER COMMENTS:

Patient Information (Must be completed before services can be rendered)

Name: _____
First Middle Last

Social Security Number: _____

Name of Primary Insurance Carrier: _____

Name of Insured: _____ Insured date of birth: _____

Insured social security number: _____

Insured Address (If different than your own): _____

City, State, Zip:_____

Name of Secondary Insurance Carrier: _____

Name of Insured: _____ Insured date of birth: _____

Insured social security number: _____

Insurance Policies and Fee Schedules

- **Consultation—** includes practice member history. This service is complimentary.
- **Assessment (new or established practice member)**— includes one or more of the following: thermography, surface electromyography, range of motion, postural analysis, motion and/or static palpation, leg check — $30-$100
- **Chiropractic Adjustment**— the actual correction of vertebral misalignments. A sound may or may not be heard. If there is no auditory component, it does not mean that the adjustment has not taken place. — $40-$60
- **X-Rays**— Specific x-ray views taken of your spine to determine a misalignment/subluxation of your vertebrae. These can also be used to indicate progress after a period of care. — $40+ per view
  - **The fee for copying your X-rays on a disc is $15.00. This fee must be paid in advance. Digital X-rays on disc will be available within 72 business hours of prepayment.**

Financial Responsibility

I hereby authorize payment to be made directly to Turning Point Chiropractic, for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to Turning Point Chiropractic for any and all services I receive at this office. I understand and agree that all services rendered to me will be charged to me, and I'm responsible for timely payment of such services. Should my account be assigned to a collection agency, I understand that I am responsible for any and all associated fees set forth by the collection agency. This may be up to 50 percent of the amount I owe to Turning Point Chiropractic.

_____ _____
Parent or Legal Guardian's Signature Date

TPC Team Initial_____

Parental Consent

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an "arterial dissection" that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately a percentage of these patients will experience a stroke.

The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events/per one million persons/year and risk of death has been estimated as 104 per one million users.

It is also important that you understand there are treatment options available for your child's condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your child's circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my child's circumstance. I intend this consent to cover the entire course of care from all providers in this office for my child's present condition and for any future condition(s) for which I seek chiropractic care from this office.

I understand that I am directly and fully responsible to Turning Point Chiropractic for all fees associated with chiropractic care my child receives.

□ Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/former spouse or other guardian is not required. If my authority to so select and authorize this care should change in any way, I will immediately notify this office.

_____ _____

Parent or Legal Guardian's Signature Date

_____

Relation to Minor

FEMALES ONLY: X-rays/Imaging Studies

Please read carefully and check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our receptionist for further explanation.

◯ The first day of my female child's last menstrual cycle was on _____ (Date)

◯ To the best of my knowledge, my female child is not pregnant.

By my signature below I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration I therefore, do hereby consent to any diagnostic x-ray examination the doctor has deemed necessary in my minor female child's case.

_____ _____

Parent or Legal Guardian's Signature Date

◯ Patient is pregnant or may be pregnant and therefore **NOT A CANDIDATE** for x-rays at this time.

Turning Point Chiropractic NOTICE OF PRIVACY PRACTICE

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your **P**ersonal **H**ealth **I**nformation. In addition we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or as **dictated by our office policy,** we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. If you would like an additional copy, one may be requested. Once you have read this notice, please sign the last page, and return only the signature page (page 2) to our front desk receptionist. Keep this page for your records.

PERMITTED DISCLOSURES:

1. Treatment purposes - discussion with other health care providers involved in your care.
2. Inadvertent disclosures - open treating area mean open discussion. If you need to speak privately to the doctor, please let our staff know so we can place you in a private consultation room.
3. For payment purposes - to obtain payment from your insurance company or any other collateral source.
4. For workers compensation purposes - to process a claim or aid in investigation.
5. Emergency - in the event of a medical emergency we may notify a family member.
6. For Public health and safety - in order to prevent or lessen a serious or eminent threat to the health or safety of a person or general public.
7. To Government agencies or Law enforcement - to identify or locate a suspect, fugitive, material witness or missing person.
8. For military, national security, prisoner and government benefits purposes.
9. Deceased persons - discussion with coroners and medical examiners in the event of a patient's death.
10. Telephone calls, text messages or emails and appointment reminders - **we may call your home and leave messages** regarding a missed appointment or apprize you of changes in practice hours or upcoming events.
11. Change of ownership- in the event this practice is sold, the new owners would have access to your PHI.

YOUR RIGHTS:

1. To receive an accounting of disclosures.
2. To receive a paper copy of the comprehensive "Detail" Privacy Notice.
3. To request mailings to an address different than residence.
4. To request Restrictions on certain uses and disclosures and with whom we release information to, although we are not required to comply. If, however, we agree, the restriction will be in place until written notice of your intent to remove the restriction.
5. To inspect your records and receive one copy of your records at no charge, with notice in advance.
6. To request amendments to information. However, like restrictions, we are not required to agree to them.
7. To obtain **one copy** of your records at no charge, when timely notice is provided (72 hours). **X-rays** are original records and you are therefore not entitled to them. If you would like us to outsource them to an imaging center, to have copies made, we will be happy to accommodate you. However, you will be responsible for this cost.

COMPLAINTS:

If you wish to make a formal complaint about how we handle your health information, please call the HIPPA Compliance Office at Turning Point Chiropractic at 920.785.8802. If they are unavailable, you may make an appointment with the receptionist to see the compliance officer within 72 hours or 3 working days. If you are still not satisfied with the manner in which this office handles your complaint, you can submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Ave. SW
Room 509F HHH Building
Washington DC 20201

Parent/Guardian initials: **_____-retaining previous page**

Turning Point Chiropractic NOTICE REGARDING YOUR RIGHT TO PRIVACY continued…

I have received a copy of Turning Point Chiropractic's Patient Privacy Notice. I understand my rights as well as the practice's duty to protect my health information, and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this "Notice of Privacy Practice" at a time in the future and will make the new provisions effective for all information that it maintains past and present.

As a patient, I understand that open adjusting bays are utilized, and with the nature of open adjusting bays I acknowledge and accept that my personal information may be heard by another person in the office. If confidentiality is required, I agree to schedule a private appointment to discuss my information.

I am aware that a more comprehensive version of this "Notice" is available to me. At this time, I do not have any questions regarding my rights or any of the information I have received.

_____

Parent or Legal Guardian's Signature

_____ _____

Parent/Guardian Signature Date