



PEDIATRIC HEALTH QUESTIONNAIRE (Ages 2 and older)
(To be completed by legal guardian)

Please allow our staff to photocopy your driver's license and insurance cards if applicable

Name: _____
Age (Yrs.) _____ Date of Birth _____ Sex: M F # of Siblings: _____
Address: _____ City: _____ State: _____ Zip: _____
Social Sec #: _____ - _____ - _____ Email: _____@_____:_____
Home Phone: _____ - _____ - _____ Cell: _____ - _____ - _____
May we use your child's 1st name/picture for promotions? Y N
May we send you newsletters & emails? Y N
Text messages Y N Carrier? _____

Name of parent or guardian: _____ Birthdate: ____/____/____ SS#: ____-____-____
Parent Employer: _____ Occupation: _____
Emergency Contact: _____ Phone: _____ - _____ - _____ Relation: _____
Pediatrician name: _____ Phone #: _____
Obstetrician/Midwife: _____ Phone #: _____

1: Pregnancy/Birth History:

Baby delivered at _____ weeks gestation

Birth Weight _____ Birth Length _____

Please check a box for the following.

Type of birth: Vaginal Forceps Vacuum Extraction Planned Cesarean Emergency Cesarean

Baby head presentation: Normal Sunny side up (face) Breech

Intervention: Pitocin Cervidil Epidural Pain medication Other, please describe _____

Describe any problems during labor or delivery: _____

Any traumas during pregnancy? (Including falls or motor vehicle accidents) If yes, please describe:

Any hospitalizations during pregnancy? If yes, please describe: _____

Any medications during pregnancy, including over the counter medication? If yes, please describe:

Any fertility treatment? If yes, please describe: _____

Congenital Defects/Abnormalities? _____

Present at birth? Meconium Jaundice (yellow) Cyanosis (blue) Fetal distress

Intensive care?: not required was required ___ Days in neonatal intensive care unit

(Continue on next page)

2: Infant/Toddler History (For children 2-4 please fill out) (5 years and older skip to section 3)

Child is: Bottle Breast (prefers Right side Left side Feeds equally) Eating Solids

When did child begin solids? _____ What solids is child eating? _____

Does child become irritable during diaper changes? Yes No

Is child toilet trained? Yes No If yes, when did they start? _____

Does child have preferred head position? Yes No If yes, which side _____

Does child frequently arch his/her head and neck backwards? Yes No

Does your child ever bang his/her head repeatedly against a wall, bed or other object?: Yes No

3: All Children Health History:

Present Complaint/Concern: _____

When did this problem first occur? _____

Has your child been previously treated for this problem? Yes No If yes, where? _____

Does your child complain of pain? Yes No If yes, where? _____

Number of bowel movements per day? _____

Do you have any concerns about your child's diet? YES NO if yes, please describe:

Is your child involved in sports? YES NO if yes, please describe, which ones:

How much time does child spend with electronics including tv, computers, phones and tablets? _____

Has your child been treated on an emergency basis? YES NO if yes, please describe:

Date of last MD visit _____ Reason: _____

Surgeries: _____

Medications/Vitamins: _____

Accidents/Injuries/Falls: _____

Vaccine Schedule: Fully vaccinated Altered schedule for vaccination Not vaccinated

Childhood diseases (check all that apply): Chickenpox Mumps Rubella Measles Whooping cough

Other _____

Please check ALL health conditions child has had, even if they do not seem related to current problem

Ear Infections Fevers Colic Acid Reflux Asthma / Allergies Colds/Flu Constipation Bed Wetting

Diarrhea Excessive Gas Urinary infections Kidney Infections Poor Appetite Digestive issues Ulcers

Altered Sugar Levels Diabetes (Type I Type II) Heartburn High Blood Pressure Low Blood Pressure

Dizziness Fainting Seizures Loss of Balance Hyperactivity Temper tantrums Behavior Problems

Mood Swings Anxiety/Nervousness Headaches Back Aches Neck Pain Growing Pains

Arm Problems Leg Problems Scoliosis Arthritis Rheumatoid Arthritis Joint Problems Muscle Jerking

Numbness/Tingling Orthopedic Problem Walking Problems Broken Bones Ruptures/Hernias

Convulsions Heart Problems Stroke Cancer/Tumor Genetic Disorders Tuberculosis Anemia

Rheumatic Fevers Hearing Trouble Sinus Trouble Vision Issues Rashes/Skin problems

Other(List): _____

Family History: Please check box if Mother/Father/Grandparents or Siblings have the following:

Alcoholism High Blood Pressure Heart disease Heart failure Stroke Cancer Diabetes

Kidney disease Asthma Thyroid disease Arthritis HIV/AIDS Other _____

(Continue on next page)

CONSENT TO TREAT

Being the parent or legal guardian of this child, I hereby authorize this office and its doctors to examine and administer care to my son/daughter named _____ as the examining /treating doctor deems necessary.

I understand and agree that I am personally responsible for payment of all fees charged by this office for such care.

Parent's Name: _____

Signature: _____ Date: _____

INFORMATION AND RESPONSIBILITIES

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that McAvoy Chiropractic will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to McAvoy Chiropractic will be credited to my account upon receipt. However, I clearly understand and agree that all fees for professional services rendered to me will be immediately due and payable. I also understand that occasionally insurance companies will send the checks to me; and I should contact McAvoy Chiropractic before cashing them to see if they represent my bill with McAvoy Chiropractic. By signing this agreement, I hereby authorize the Doctor to treat my condition as she deems appropriate. It is understood and agreed the amount paid to McAvoy Chiropractic for x-rays is for examination only and the x-ray negatives will remain the property of this office, being on file where they may be seen at any time. The patient also agrees to total responsibility for all bills incurred in this office.

Patient Signature: _____ Date: ___/___/20_____

Guardian or Spouse, if authorizing care: _____

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is obligated to agree to those restrictions only to the extent they coincide with state and federal law.
3. A patient's written consent need only be obtained one time for all subsequent care given to the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. Our office may contact you periodically regarding appointments, treatments, products, services, or charitable work performed by our office. You may choose to opt-out of any marketing or fundraising communications at any time.
6. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
7. Patients have the right to file a formal complaint with our privacy official and the Secretary of HHS about any possible violations of these policies and procedures without retaliation by this office.
8. Our office reserves the right to make changes to this notice and to make the new notice provisions effective for all protected health information that it maintains. You will be provided with a new notice at your next visit following any change.
9. This notice is effective on the date stated below.
10. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

By signing below, I am stating that I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Patient Signature: _____ Date: ___/___/20_____

If the patient is a minor: I hereby authorize McAvoy Chiropractic to treat my child: _____

Parent/Guardian Signature: _____ Date: ___/___/20_____

(Continue on next page)

INFORMED CONSENT: McAvoy Chiropractic

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective. It is equally important that each patient understand the methods that will be used to attain that objective. This will prevent any confusion or disappointment.

Health is defined as a state of optimal physical, mental and social well being, not merely the absence of disease or infirmity.

Subluxation(s) is/are misalignment of one (segmental subluxation) or more (global subluxation) of 24 vertebra in the spinal column or extremities which causes alteration of nerve function. This results in lessening of the body's innate ability to express its maximum health potential.

The nature of chiropractic treatment- The doctor will use her hands or a mechanical device in order to move your joints. This is called a chiropractic adjustment. The purpose of a chiropractic adjustment is to reduce or eliminate subluxation(s). You may feel a "click" or "pop," such as the noise when a knuckle is "cracked," and you may feel movement of the joint. Various ancillary procedures, such as examination, x-rays, hot or cold packs, electric muscle stimulation, therapeutic ultrasound, IASTM, cold laser therapy, and traction may also be used.

Nutrition – Any nutritional recommendations are not for the treatment or prevention of any disease or condition. Nutritional recommendations are made solely for the purpose of supporting the physiological and biochemical processes of the human body.

Possible risks or probability of risks occurring – As with any health care procedure, complications, although rare, are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury, or stroke, could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or other minor complications. The risks of complications due to chiropractic treatment have been described as "rare." about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury, or stroke, has been estimated at one in one million to one in ten million, and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered "rare." I will make every effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

Other treatment options that could be considered may include the following:

- Over-the-counter analgesics. The risks of these medications include irritation to stomach, liver and kidneys and other side effects in a significant number of cases.
- Medical care, typically anti-inflammatory drugs, tranquilizers and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.
- Hospitalization in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.
- Surgery in conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

Risks of remaining untreated – Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition, and make future rehabilitation more difficult.

We do not offer to diagnose or treat any disease or condition. However, if we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area. We offer no guarantee of symptom relief. We do not offer advice regarding treatment prescribed by others. Our only practice objective is to reduce or eliminate subluxation(s), and support the physiological and biochemical processes of the human body.

I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and hereby give my full consent to treatment.

Patient Name (Printed)

Patient or Guardians Signature

Date