PEDIATRIC HEALTH QUESTIONNAIRE (Ages Newborn-1 year)

(To be completed by legal guardian)

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

Name: _____

Age (Yrs.) _____ (mos.) _____Date of Birth _____Sex: M F # of Siblings: _____

Address: _____ City: _____State: _____ Zip: _____

Social Sec #: ___-___-_____ Email: _____@_____._____

Home Phone: _____-____-_____ Cell: ___-____-_____May we use your/child 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:

Birth Weight_____ __Birth Length_____

Baby delivered at _____weeks gestation

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

Location: □ Home □ Hospital □ Birthing Center

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

(Continue on next page)

Immediately following birth:

APGAR Scores: at 1 minute ___/10 At 5 minutes ___/10

Baby's cry: □ Strong cry immediately □ Weak cry immediately □ Did not cry for ___minutes

Baby's color: □ Pink all over □ Blue face □ Blue hands/feet

Baby's activity: □ Arms and legs actively moving □ Floppy baby

Intensive care: □ was required ___Days in neonatal intensive care unit

Medication given at birth _____ Vaccines administered _____

2: Infant History:

Infant Feeding: □ Bottle □ Breast (prefers □ Right side □ Left side □ Feeds equally) □ Eating Solids

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

Number of bowel movements per day: _____

Does child become irritable during diaper changes? □ Yes □ No

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

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

Child's average number of hours slept per night: _____ Quality of sleep: □ Good □ Poor

Does your child cry a lot? □ Yes □ No If yes, how many hours per day_____

Is your child able to (check all that apply): □ Respond to sound □ Hold head up □ Roll over
□ Sit alone □ Follow object with eyes □ Crawl □ Stand □ Walk alone

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: _____

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 <u>ALL</u> 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_____

CONSENT TO TREAT A MINOR

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 RESPONSIBILITES

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_____

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