PFC Pediatric New Patient Paperwork

Pediatric Patient Questionnaire

1. CONFIDENTIAL PATIENT INFORMATION:

Child's Name: _____ Date of Birth: _____ Gender at birth: _____

Parent/Guardian Name(s): _____ Child's Social Security #: _____

Street Address: _____ Apt./Unit #: _____ City: _____ State: _____ Zip Code: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

Email: _____ Height: _____ Weight: _____

Who is your primary care physician?

_____

2. How did you hear about us? (please select all that apply & list who in the box that appears)

☐ Current Patient (list who) _____

☐ Professional Referral/Doctor (list who) _____

☐ Google Search _____

☐ Facebook _____

☐ Community Partner (list who) _____

☐ Other (specify) _____

3. Is your child receiving care from any other health professionals?

○ Yes ○ No

4. If yes, please name them and their specialty:

	Name	Specialty
1		
2		
3		

Others:

_____

5. Please list any drugs/medications/vitamins/herbs/other that your child is taking:

	Medication Name	Dosage	Frequency	Reason for Taking
1				
2				
3				

Others:

_____

CURRENT HEALTH CONDITIONS

6. What are the primary health concerns for your child?

_____

_____

_____

_____

7. Please describe when your child's issues first began and how they've progressed since:

_____

_____

_____

_____

8. What makes things better?

_____

_____

_____

_____

9. What makes things worse?

_____

HEALTH GOALS FOR YOUR CHILD

10. What are your top three health goals for your child:

1.

_____

2.

_____

3.

11. What would you like to gain from chiropractic care?

- ○ Resolve existing condition
- ○ Overall wellness + prevention
- ○ Both

12. Have you ever visited a chiropractor?

- ○ Yes
- ○ No

If yes, what is their name:

13. What is their specialty?

- ○ Pain Relief
- ○ Physical Therapy & Rehab
- ○ Nutritional
- ○ Subluxation-based
- ○ Other

If other, specify:

PREGNANCY & FERTILITY HISTORY

Please tell us about your pregnancy.

14. Any fertility challenges?

- ○ Yes
- ○ No

15. If yes, please explain:

16. Did mother smoke?

- ○ Yes
- ○ No

If yes, how many per week?

17. Did mother drink?

- ○ Yes
- ○ No

If yes, how many per week?

18. Did mother exercise?

○ Yes ○ No

19. If yes, please explain:

20. Was mother ill?

○ Yes ○ No

21. If yes, please explain:

22. Any ultrasounds?

○ Yes ○ No

23. If yes, please explain:

24. Please explain any notable episodes of emotional or physical stress during your pregnancy:

25. Please explain any other concerns or notable remarks about your child's conception or pregnancy:

LABOR & DELIVERY HISTORY

26. Child's birth was:

○ Vaginal Birth ○ Scheduled C-section ○ Emergency C-section

At how many week's was your child born?

_____

27. Child's birth was:

○ At home ○ At a birthing cente ○ At a hospital

○ Other

If other, specify:

_____

28. Birth Provider's Name:

_____

29. Please check any applicable interventions or complications:

☐ Breech ☐ Induction ☐ Pain meds

☐ Manual assistance ☐ Epidural ☐ Episiotomy

☐ Vacuum extraction ☐ Forceps ☐ Cord-wrapped

If other, specify:

_____

30. Please describe any other concerns or notable remarks about your child's labor and/or delivery.

_____

_____

_____

_____

31. Child's birth weight: _____

Child's birth height: _____

APGAR score at birth: _____

APGAR score at 5 minutes: _____

GROWTH & DEVELOPMENT HISTORY

32. Is/was your child breastfed?

○ Yes ○ No

If yes, how long?

_____

33. Difficulty with breastfeeding?

○ Yes ○ No

If yes, is there a certain side that is more difficult for them?

_____

34. Did they ever use formula?

○ Yes ○ No

35. If yes:

At what age:

_____

36. Did/does your child ever suffer from colic, reflux, skin issues, or constipation as an infant?

○ Yes ○ No

37. If yes, please explain:

_____

_____

_____

_____

38. Did/does your child frequently arch their neck/back, feel stiff, or bang their head?

○ Yes ○ No

39. If yes, please explain:

_____

_____

_____

_____

40. At what age did the child:

	Age
Respond to sound:	
Follow an object:	
Hold their head up:	
Vocalize:	
Teething:	
Sit alone:	
Crawl:	
Walk:	
Begin cow's milk:	
Begin solid foods:	

41. Please list any food intolerance or allergies, and when they began:

	Food intolerance / Allergy	When they began
1		
2		
3		

42. Please list your child's hospitalization and surgical history, including the year:

	Hospitalization / Surgery	Year
1		
2		
3		

43. Please list any major injuries, accidents, falls and/or fractures your child has sustained in his/her lifetime, including the year:

	Injury	Year
1		
2		
3		

44. Have you chosen to vaccinate your child?

- ○ No
- ○ Yes, on a delayed or selective schedule
- ○ Yes, on schedule

45. If yes, please list any vaccination reactions:

_____

_____

_____

_____

46. Has your child received any antibiotics?

- ○ Yes
- ○ No

47. If yes, how many times and list reason:

_____

_____

_____

_____

48. Any difficulty with bonding or social development?

○ Yes ○ No

49. If yes, please explain:

_____

_____

_____

_____

50. Night terrors or difficulty sleeping?

○ Yes ○ No

51. If yes, please explain:

_____

_____

_____

_____

52. Behavioral, social or emotional issues?

○ Yes ○ No

53. If yes, please explain:

_____

_____

_____

_____

54. How many hours per day does your child typically spend watching a TV, computer, tablet or phone?

_____

55. How would you describe your child's diet?

○ Mostly whole, organic foods ○ Pretty average ○ High amount of processed foods

56. Are there other health concerns, or is there anything else you'd like us to know about your child?

_____

_____

_____

_____

ACKNOWLEDGEMENT & CONSENT

Patient or Parent/Guardian

Signature

Date

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.

57.

	Past	Present
Colic & Excessive Crying		
Difficulty Latching / Nursing		
Reflux & Excessive Spit Up		
Projectile Vomiting		
Frequent Stiffening, Rigidity, Arching		
Difficulty Sleeping		
Torticollis		
Plagiocephaly		
Motor Milestone Delays		
Low Tone & Coordination Challenges		
Speech & Communication Delays		
Sensory Processing Challenges		
Social / Emotional Challenges		
Frequent Tantrums & Meltdowns		
Behavior Issues		
Hyperactivity & Impulsivity		
Anxiety & Emotional Instability		
ADHD / ADD		
Balance & Coordination Issues		
Visual & Auditory Processing Challenges		
Handwriting & Fine Motor Challenges		
Low Energy and Fatigue		
Depression & Lack of Confidence		
Lightheadedness & Dizziness		

Frequent Naseau & Malaise		
Headaches & Migraines		
Stick Neck & Shoulders		
Jaw, Swallowing, Sensory Food Aversions		
Vision & Hearing Issues		
Ear & Sinus Infections		
Sore Throat and Strep		
Swollen Tonsiles & Adenoids		
Strep & Upper Respiratory Infections		
Allergies and Autoimmune Challenges		
Chronic Inflammation		
Poor Metabolism & Weight Control		
Chronic Chest Colds & Cough		
Bronchitis & Pneumonia		
Asthma		
Blood Sugar Problems		
Skin Conditions / Rash		
Ulcerative Colitis, Crohn's, IBS		
Kidney Challenges		
Gas Pain & Bloating		
Gluten & Casein Intolerance		
Constipation		
Bladder & Urination Issues		
Hormonal Challenges		
Low Back Pain & Stiffness		
Lumbopelvic / SI Joint Pain		
Tight Hamstrings & Calves		
Toe Walking		
Poor Circulation & Cold Feet		
Weak Ankles & Arches		

58. _____

HIPAA Notice of Privacy Practices

Effective Date: 02-16-26

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Questions? Contact our Privacy Officer at 802-362-7512

Our Obligations

We are required by law to: (1) maintain the privacy of your protected health information (PHI); (2) provide you with this Notice; (3) follow the terms of the current Notice; and (4) notify you promptly if a breach of your unsecured PHI occurs.

How We May Use and Disclose Your Health Information

We may use and disclose your Health Information without written authorization for the following purposes. All other uses require your written authorization, which you may revoke in writing at any time.

Treatment, Payment, and Health Care Operations (TPO).

We may use and disclose your Health Information to provide and coordinate your medical care (e.g., sharing records with a specialist); to bill and collect payment from you, your insurer, or another payer; and to manage our practice and ensure quality care, including evaluating the quality of obstetric or gynecologic services you receive.

Other Permitted Uses and Disclosures.

We may also use or disclose Health Information, to the extent permitted or required by law, for the following purposes:

- **Appointment reminders, treatment alternatives, and health-related benefits or services.**
- **Individuals involved in your care or payment, such as family members, or for disaster relief notification.**
- **Research, subject to a special approval process and applicable legal protections.**
- **As required by federal, state, or local law.**
- **To avert a serious and imminent threat to health or safety.**
- **To business associates who perform services on our behalf, under written confidentiality agreements.**
- **Organ and tissue donation organizations.**
- **Military command authorities or foreign military authorities, if applicable.**
- **Workers' compensation or similar programs.**
- **Public health activities (e.g., disease reporting, abuse reporting, product recalls).**
- **Health oversight agencies for audits, investigations, inspections, and licensure.**
- **Judicial and administrative proceedings, in response to a court order or lawful process.**
- **Law enforcement, in response to legal process or as otherwise permitted by law.**
- **Coroners, medical examiners, and funeral directors.**
- **National security, intelligence, and protective services for authorized federal officials.**
- **Correctional institutions or law enforcement, if you are an inmate or in custody.**

Uses and Disclosures Requiring Your Written Authorization.

We will not use or disclose your Health Information without your written authorization for: (1) psychotherapy notes; (2) marketing purposes; or (3) any sale of Health Information. You may revoke any such authorization in writing at any time.

Substance Use Disorder (SUD) Records — Additional Protections

If we receive or maintain records related to your treatment, diagnosis, or referral for a substance use disorder, those records are subject to heightened federal protections under 42 CFR Part 2, in addition to HIPAA.

- **Consent required:** Unlike general PHI, SUD Records generally cannot be used or disclosed for treatment, payment, or health care operations without your written consent. You may provide a single written consent covering all future TPO uses and disclosures.
- **Legal proceedings restriction:** SUD Records may not be used or disclosed in civil, criminal, administrative, or legislative proceedings against you without your written consent or a court order issued after notice and an opportunity to be heard, as provided in 42 CFR Part 2.
- **No re-disclosure:** Recipients of your SUD Records are prohibited from re-disclosing them unless permitted by federal law or your written consent.
- **Your rights:** You have the same privacy rights for your SUD Records as for other Health Information, including the rights described below.

Your Rights

- **Inspect and copy your records:** You have the right to inspect and copy your medical and billing records (excluding psychotherapy notes) used to make decisions about your care, including the right to receive an electronic copy if records are maintained electronically. Submit a written request to our Privacy Officer.
- **Amend your records:** You may request that we amend incorrect or incomplete Health Information by submitting a written request to our Privacy Officer.
- **Accounting of disclosures:** You may request a list of certain disclosures we have made for purposes other than TPO or where you provided authorization. Submit a written request to our Privacy Officer.
- **Request restrictions:** You may request restrictions on how we use or disclose your Health Information. We are not required to agree — except that if you pay out-of-pocket in full for a service and request we not share that information with your health plan, we must honor that restriction. Submit a written request to our Privacy Officer.
- **Confidential communications:** You may request that we communicate with you in a specific way or at a specific location (e.g., by mail only, or at your work address). Submit a written request to our Privacy Officer.
- **Paper copy of this Notice:** You may request a paper copy of this Notice at any time, even if you agreed to receive it electronically.
- **Breach notification:** You have the right to be notified in writing within 60 days if a breach of your unsecured PHI occurs.

Changes to This Notice

We reserve the right to change this Notice and apply revised terms to all Health Information we hold. A current copy is posted in our office. The effective date appears at the top of this Notice.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with our Privacy Officer or with the U.S. Department of Health and Human Services, Office for Civil Rights (www.hhs.gov/ocr/privacy/hipaa/complaints, 1-800-368-1019). You will not be penalized for filing a complaint.

Privacy Officer Contact

Kathleen Pinkus Dc

802-362-7512

Acknowledgment of Receipt

By signing below, I acknowledge receipt of this Notice of Privacy Practices and the opportunity to review its contents.

	02-16-26	
Patient Signature	Date	Printed Name

PATIENT HIPAA CONSENT FORM

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

** You may refuse to sign this acknowledgement. **

Release of Protected health information/HIPAA By signing this form, you are granting consent to Drs. Brenton and Kathleen Pinkus and/or Pinkus Family Chiropractic to use and disclose your protected health information for the purpose of treatment, payment and health care operations.

Our notice of Privacy Practices provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review our

Notice of Privacy Practices before you sign this consent, and we encourage you to read it in full. Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by contacting us at . You have a right to request us to restrict how we use and disclose your protected health information. We are not required by law to grant your request. However, if we do grant your request, we are bound by our agreement. You have a right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your request. Acknowledgement of receipt of notice or privacy practices I have received a copy of the office's Notice of Privacy Practices.

I understand that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

Conduct, plan and direct my treatment and follow-up among the healthcare providers who may be directly and indirectly involved in providing my treatment.

Obtain payment from third-party payers.

Conduct normal healthcare operations such as quality assessments and accreditation.

I, _____ have been offered to read and receive a copy of this office's Notice of Privacy Practices and give my consent for this office to use personal health information.

Patient Name:_____

Patient Signature Or Parent/Guardian:_____ Date:_____

AUTHORIZATION FOR CARE

I hereby authorize the doctors and staff at Pinkus Family Chiropractic to treat my condition as deemed appropriate. At Pinkus Family Chiropractic, we do not diagnose or treat any disease or condition other than vertebral subluxation and the doctors/clinic will not be held responsible for any pre-existing medical conditions. I certify that the above information is correct to the best of my knowledge. I will not hold the doctors or any staff member of Pinkus Family Chiropractic responsible for any errors or omissions that I may have made in the completion of this form. Chiropractic, as well as all other types of health care is associated with potential risks in the delivery of treatment. While chiropractic treatment is remarkably safe, you need to be informed about the potential risks related to your care to allow you to be fully informed before consenting to treatment. Please inquire if you have further questions. Chiropractic is a system of health care delivery and therefore, as with any health care delivery system, we cannot promise a cure for any symptom, condition, or disease as a result of treatment in this office. An attempt to provide you with the very best care is our goal, and if the results are not acceptable, we will refer you to another provider who we feel can further assist you.

Patient Name:_____

Signature- (Patient or Parent/Guardian):_____ Date:_____

Informed Consent

We encourage and support a **shared decision making process** between us regarding your health needs. As a part of that process you have a right to be informed about the condition of your health and the recommended care and treatment to be provided to you so that you can make the decision whether or not to undergo such care with full knowledge of the known risks. This information is intended to make you better informed in order that you can knowledgeably give or withhold your consent.

Chiropractic is based on the science which concerns itself with the relationship between structures (primarily the spine) and function (primarily the nervous system) and how this relationship can affect the restoration and preservation of health.

Adjustments are made by chiropractors in order to correct or reduce spinal and extremity joint subluxations. **Vertebral subluxation** is a disturbance to the nervous system and is a condition where one or more vertebra in the spine is misaligned and/or does not move properly causing interference and/or irritation to the nervous system. The primary goal in chiropractic care is the removal and/or reduction of nerve interference caused by vertebral subluxation.

A chiropractic examination will be performed which may include spinal and physical examination, orthopedic and neurological testing, palpation, specialized instrumentation.

The chiropractic adjustment is the application of a precise movement and/or force into the spine in order to reduce or correct vertebral subluxation(s). There are a number of different methods or techniques by which the chiropractic adjustment is delivered but are typically delivered by hand. Some may require the use of an instrument or other specialized equipment. Among other things, chiropractic care may reduce pain, increase mobility and improve quality of life.

In addition to the benefits of chiropractic care and treatment, one should also be aware of the existence of some risks and limitations of this care. The risks are seldom high enough to contraindicate care and all health care procedures have some risk associated with them.

Risks associated with some chiropractic treatment may include soreness, musculoskeletal sprain/strain, and fracture. In addition there are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke; rather, recent studies indicate that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence, there is a stroke already in process. However, you are being informed of this reported association because a stroke may cause serious neurological impairment.

I have been informed of the nature and purpose of chiropractic care, the possible consequences of care, and the risks of care, including the risk that the care may not accomplish the desired objective. Reasonable alternative treatments have been explained, including the risks, consequences and probable effectiveness of each. I have been advised of the possible consequences if no care is received. I acknowledge that no guarantees have been made to me concerning the results of the care and treatment.

I HAVE READ THE ABOVE PARAGRAPH. I UNDERSTAND THE INFORMATION PROVIDED. ALL QUESTIONS I HAVE ABOUT THIS INFORMATION HAVE BEEN ANSWERED TO MY SATISFACTION. HAVING THIS KNOWLEDGE, I KNOWINGLY AUTHORIZE PWC CHIROPRACTIC TO PROCEED WITH CHIROPRACTIC CARE AND TREATMENT.

Patient Name:_____ DOB:_____

Patient Signature Or Parent/Guardian:_____

Relationship to Patient:_____

In addition, by signing below, I give permission for the above named minor patient to be managed by the doctor even when I am not present to observe such care.

Patient Name:_____

Name of person legally authorized to sign for:_____

Relationship to Patient:_____

FINANCIAL POLICY

Our goal is to provide the highest quality of healthcare possible for our patients. In order to achieve this goal, we need your commitment as well.

- We urge our patients to follow the doctor's recommendations for care. Please keep your appointments as scheduled or call our office within 24 hours to make any changes. In order to attain the level of achievement we both desire, care must be followed.
- I authorize Pinkus Family Chiropractic to release any information deemed appropriate concerning my physical condition to any insurance company, attorney, or adjuster in order to process any claim for reimbursement charges incurred by me.
- If using insurance which may include benefits for Chiropractic Care, I understand that my insurance policy may have a co-payment or deductible and I will be responsible for those charges and any services denied or not covered by my insurance company at each visit. I also realize my care may be subject to pre-authorization by the insurance company, and I accept any responsibility for charges not approved. The insurance company will review any/all documentation submitted by Pinkus Family Chiropractic for their assessment of medical necessity and base their approval/denial upon this documentation. I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account for professional services rendered.
- Your health insurance does not pay for everything, even some care that you or your health care provider have good reason to think you need. We know that some health insurance policies will not pay for items and services such as your initial visit and any chiropractic care deemed maintenance or wellness care by your carrier as well as other items such as massage therapy, examinations and taping. Signing below signifies that you want these items and services but understand that some of these services will not be billed to your insurance company. Therefore, you are responsible for payment and cannot appeal to your insurance carrier as services were not submitted and/or billed to them.
- I authorize the direct payment to Pinkus Family Chiropractic of any sum I now or hereafter owe by my attorney out of settlement of my case, and by any insurance company obligated to make payment to me or Pinkus Family Chiropractic based in whole or in part upon the charges made for services received. I hereby appoint Pinkus Family Chiropractic authority to endorse and cash checks, drafts, or money orders made payable to the undersigned or as co-payee with this clinic or payments due for services rendered on behalf of the undersigned by:
- I understand there are discounted fees, family plans and pre-paid visit discounts available to patients who do not have insurance or
- choose not to use insurance and will be furnished with these options at my first visit.
- If you have other questions, please ask our staff. Signing below means that you have received and understand this notice

Patient Name:_____

Signature- (Patient or Parent/Guardian):_____ Date:_____

Patient Authorization for Chiropractic Care in an "Open Adjusting" Environment"

It is the practice of this office to provide chiropractic care in an "open adjusting" environment. Patients are within the site of one another and some ongoing routine details of care are discussed within earshot of other patients and staff. This environment is used for ongoing care and is not the environment used for taking patient histories, performing examinations or presenting reports of findings. These procedures are completed in a private, confidential setting.

We are requesting this authorization of you due to various interpretations under federal law with respect to what is known as an "incidental disclosures" of health information. It is our view that the kinds of matters related in an "open adjusting" environment are incidental matters. In the event you or someone else would not agree with us we are providing this disclosure.

The use of this format is intended to make your experience with our office more efficient and productive as well as to enhance your access to quality health care and health information. If you choose not to be adjusted in an "open adjusting" environment other arrangements will be made for you. Your decision will have no adverse effects on your care from Dr. Katie and Dr. Brenton or your relationship with our staff.

Your signature indicates your authorization of this activity.

This authorization may be revoked by you at any time. Revocation may be accomplished by advising us in writing of your desire

to withdraw your authorization. Please allow a reasonable processing time for the change in our procedures to be completed.

Patient Name:_____

Signature- (Patient or Parent/Guardian):_____ Date:_____

Pinkus Family Chiropractic

Good Faith Estimate Disclaimer

By law, we are required to provide all uninsured/self-pay patients a good faith estimate for scheduled visits. The good faith estimate you have received was generated based on what you have requested to be seen for. We have provided, with our best knowledge of your requirements for care, what you are likely to owe out of pocket for services rendered.

The good faith estimate you have received is an estimate only and is subject to change. There may be additional items or services not contained in this estimate that are recommended by the provider as part of your course of care. These items must be scheduled separately and are not reflected in today's estimate; however, you may obtain another estimate for any other visits and procedures recommended. Please notify the checkout desk so they can have the billing department contact you. You could be charged more if there are complications or special circumstances. Federal law allows you to dispute the bill if this occurs.

You have the right to initiate a patient-provider dispute if the actual billed charges are $400 more than the expected charges included in the good faith estimate. Disputes must be filed within 120 calendar days. You may initiate a dispute by printing down and filling out a dispute form from our website, pinkusfamilychiropractic.com or calling 802-362-7512. You may also start a dispute with the U.S. Department of Health and Human Services (HHS). You may inquire with them at cms.gov/nosurprises or 1-877-696-6775. They require a $25 fee to use their dispute process.

Please note that the good faith estimate is not a contract and you are not required to obtain these services. You may cancel your appointment if you do not wish to be seen after receiving this estimate. If you have insurance we don't participate with, you may receive these services from a different office that does participate. If you choose to go elsewhere, you understand that their charges differ from ours.