

Pediatric Patient Questionnaire

CONFIDENTIAL PATIENT INFORMATION

Child's Name:	Parent/Guardian Name(s):		
Street Address:	City:	State:	Zip:
Cell Phone: - -	Home Phone: - -	Work Phone: - -	
Email:	Child's SS #: - -	Birthdate: / /	Age:
How did you hear about us?		Height: ft. in.	Weight: lbs.
Who is your primary care physician?			
Is your child receiving care from any other health professionals? <input type="radio"/> Yes <input type="radio"/> No - If yes, please name them and their specialty:			
Please list any drugs/medications/vitamins/herbs/other that your child is taking:			

CURRENT HEALTH CONDITIONS

What health condition(s) bring your child to be evaluated by a chiropractor?

When did the condition first begin? _____ How did the problem start? ☐ Suddenly ☐ Gradually ☐ Post-Injury

Has your child ever received care for this condition before? ☐ Yes ☐ No
- If yes, please explain: _____

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

What makes the problem better? _____ What makes the problem worse? _____

HEALTH GOALS FOR YOUR CHILD

What are your top three health goals for your child:	What would you like to gain from chiropractic care?
1. _____	<input type="radio"/> Resolve existing condition
2. _____	<input type="radio"/> Overall wellness
3. _____	<input type="radio"/> Both
Have you ever visited a chiropractor? <input type="radio"/> Yes <input type="radio"/> No If yes, what is their name? _____	
What is their specialty? <input type="radio"/> Pain Relief <input type="radio"/> Physical Therapy & Rehab <input type="radio"/> Nutritional <input type="radio"/> Subluxation-based <input type="radio"/> Other: _____	

PREGNANCY & FERTILITY HISTORY

Please tell us about your pregnancy

Any fertility issues? ☐ Yes ☐ No If yes, please explain: _____

Did mother smoke? ☐ Yes ☐ No If yes, how many per week? _____

Did mother drink? ☐ Yes ☐ No If yes, how many per week? _____

Did mother exercise? ☐ Yes ☐ No If yes, please explain: _____

Was mother ill? ☐ Yes ☐ No If yes, please explain: _____

Any ultrasounds? ☐ Yes ☐ No If yes, please explain: _____

Please explain any notable episodes of mental or physical stress during your pregnancy: _____

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

LABOR & DELIVERY HISTORY

Child's birth was: ☐ Natural vaginal birth ☐ Scheduled C-section ☐ Emergency C-section At how many week's was your child born?

Child's birth was: ☐ At home ☐ At a birthing center ☐ At a hospital ☐ Other: Doctor/Obstetrician's Name:

Please check any applicable interventions or complications:

☐ Breech ☐ Induction ☐ Pain meds ☐ Epidural ☐ Episiotomy ☐ Vacuum extraction ☐ Forceps ☐ Other

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

Child's birth weight: lbs. oz. Child's birth height: in. APGAR score at birth: APGAR score after 5 minutes:

GROWTH & DEVELOPMENT HISTORY

Is/was your child breastfed? ☐ Yes ☐ No If yes, how long? Difficulty with breastfeeding? ☐ Yes ☐ No

Did they ever use formula? ☐ Yes ☐ No If yes, at what age? If yes, what type?

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

- If yes, please explain:

Did/does your child frequently arch their neck/back, feel stiff, or bang their head? ☐ Yes ☐ No

- If yes, please explain:

At what age did the child: Respond to sound: _____ Follow an object: _____ Hold their head up: _____ Vocalize: _____ Teethe: _____
Sit alone: _____ Crawl: _____ Walk: _____ Begin cow's milk: _____ Begin solid foods: _____

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

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

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

Have you chosen to vaccinate your child? ☐ No ☐ Yes, on a delayed or selective schedule ☐ Yes, on schedule

- If yes, please list any vaccination reactions:

Has your child received any antibiotics? ☐ Yes ☐ No

- If yes, how many times and list reason:

Night terrors or difficulty sleeping? ☐ Yes ☐ No If yes, please explain:

Behavioral, social or emotional issues? ☐ Yes ☐ No If yes, please explain:

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

How would you describe your child's diet? ☐ Mostly whole, organic foods ☐ Pretty average ☐ High amount of processed foods

ACKNOWLEDGEMENT & CONSENT

Patient Signature: _____ Date: ____ / ____ / ____

Dr. Kyle Heimer | Foundation Family Chiropractic
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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.

REGIONS	FUNCTIONS	SYMPTOMS			
		PAST PRESENT	PAST PRESENT		
Cervical	• Autonomic Nervous System	<input type="checkbox"/> <input type="checkbox"/>	Colic & Excessive Crying	<input type="checkbox"/> <input type="checkbox"/>	Epilepsy & Seizures
	• ENT System	<input type="checkbox"/> <input type="checkbox"/>	Ear & Sinus Infections	<input type="checkbox"/> <input type="checkbox"/>	Sensory & Spectrum
	• Vision, Balance & Coordination	<input type="checkbox"/> <input type="checkbox"/>	Allergies & Congestion	<input type="checkbox"/> <input type="checkbox"/>	ADD / ADHD
	• Speech	<input type="checkbox"/> <input type="checkbox"/>	Immune Deficiency	<input type="checkbox"/> <input type="checkbox"/>	Focus & Memory Issues
	• Immune System	<input type="checkbox"/> <input type="checkbox"/>	Headaches & Migraines	<input type="checkbox"/> <input type="checkbox"/>	Anxiety & Stress
	• Digestive System	<input type="checkbox"/> <input type="checkbox"/>	Vertigo & Dizziness	<input type="checkbox"/> <input type="checkbox"/>	Balance & Coordination
	• Nerve Supply to Shoulders, Arms & Hands	<input type="checkbox"/> <input type="checkbox"/>	Sore Throat & Strep	<input type="checkbox"/> <input type="checkbox"/>	Speech Issues
	• Sympathetic Nucleus	<input type="checkbox"/> <input type="checkbox"/>	Swollen Tonsils & Adenoids	<input type="checkbox"/> <input type="checkbox"/>	TMJ / Jaw Pain
	• Metabolism	<input type="checkbox"/> <input type="checkbox"/>	Vision & Hearing Issues	<input type="checkbox"/> <input type="checkbox"/>	Stiff Neck & Shoulders
			<input type="checkbox"/> <input type="checkbox"/>	Low Energy & Fatigue	<input type="checkbox"/> <input type="checkbox"/>
		<input type="checkbox"/> <input type="checkbox"/>	Difficulty Sleeping	<input type="checkbox"/> <input type="checkbox"/>	High Blood Pressure
		<input type="checkbox"/> <input type="checkbox"/>	Pain, Numbness & Tingling in Arms to Hands	<input type="checkbox"/> <input type="checkbox"/>	Poor Metabolism & Weight Control
Upper Thoracic	• Upper G.I.	<input type="checkbox"/> <input type="checkbox"/>	Reflux / GERD	<input type="checkbox"/> <input type="checkbox"/>	Bronchitis & Pneumonia
	• Respiratory System	<input type="checkbox"/> <input type="checkbox"/>	Chronic Colds & Cough	<input type="checkbox"/> <input type="checkbox"/>	Functional Heart Conditions
	• Cardiac Function	<input type="checkbox"/> <input type="checkbox"/>	Asthma		
Mid Thoracic	• Major Digestive Center	<input type="checkbox"/> <input type="checkbox"/>	Gallbladder Pain / Issues	<input type="checkbox"/> <input type="checkbox"/>	Indigestion & Heartburn
	• Detox & Immunity	<input type="checkbox"/> <input type="checkbox"/>	Jaundice	<input type="checkbox"/> <input type="checkbox"/>	Stomach Pains & Ulcers
		<input type="checkbox"/> <input type="checkbox"/>	Fever	<input type="checkbox"/> <input type="checkbox"/>	Blood Sugar Problems
Lower Thoracic	• Stress Response	<input type="checkbox"/> <input type="checkbox"/>	Behavior Issues	<input type="checkbox"/> <input type="checkbox"/>	Allergies & Eczema
	• Filtration & Elimination	<input type="checkbox"/> <input type="checkbox"/>	Hyperactivity	<input type="checkbox"/> <input type="checkbox"/>	Skin Conditions / Rash
	• Gut & Digestion	<input type="checkbox"/> <input type="checkbox"/>	Chronic Fatigue	<input type="checkbox"/> <input type="checkbox"/>	Kidney Problems
	• Hormonal Control	<input type="checkbox"/> <input type="checkbox"/>	Chronic Stress	<input type="checkbox"/> <input type="checkbox"/>	Gas Pain & Bloating
Lumbar, Sacrum & Pelvis	• Lower G.I. (Absorption & Motility)	<input type="checkbox"/> <input type="checkbox"/>	Constipation	<input type="checkbox"/> <input type="checkbox"/>	Sciatica & Radiating Pain
		<input type="checkbox"/> <input type="checkbox"/>	Chrohn's, Colitis & IBS	<input type="checkbox"/> <input type="checkbox"/>	Lumbopelvic / SI Joint Pain
	• Gut-Immune System	<input type="checkbox"/> <input type="checkbox"/>	Diarrhea	<input type="checkbox"/> <input type="checkbox"/>	Hamstring Tightness
	• Major Hormonal Control	<input type="checkbox"/> <input type="checkbox"/>	Bed-wetting	<input type="checkbox"/> <input type="checkbox"/>	Disc Degeneration
		<input type="checkbox"/> <input type="checkbox"/>	Bladder & Urination Issues	<input type="checkbox"/> <input type="checkbox"/>	Leg Weakness & Cramps
		<input type="checkbox"/> <input type="checkbox"/>	Cramps & Menstrual Issues	<input type="checkbox"/> <input type="checkbox"/>	Poor Circulation & Cold Feet
		<input type="checkbox"/> <input type="checkbox"/>	Cysts & Endometriosis	<input type="checkbox"/> <input type="checkbox"/>	Knee, Ankle & Foot Pain
		<input type="checkbox"/> <input type="checkbox"/>	Infertility	<input type="checkbox"/> <input type="checkbox"/>	Weak Ankles & Arches
		<input type="checkbox"/> <input type="checkbox"/>	Impotency	<input type="checkbox"/> <input type="checkbox"/>	Lower Back Pain
		<input type="checkbox"/> <input type="checkbox"/>	Hemorrhoids	<input type="checkbox"/> <input type="checkbox"/>	Gluten & Casein Intolerance

Patient Name: _____

Date: ____ / ____ / ____

Foundation Family Chiropractic
455-A Old Trolley Road~Summerville~SC~29485
Dr. Kyle Heimer, D.C.

CHIROPRACTIC INFORMED CONSENT TO TREAT

I hereby consent to the performance of chiropractic procedures, including spinal manipulations (adjustments), various modes of physiotherapy, diagnostic x-rays, and any supportive therapies on me (or the patient named below, for whom I am legally responsible) by the doctor of chiropractic named above and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working with, or associated with or serving as a backup for the doctor of chiropractic named above.

I understand that chiropractic, like all forms of health care treatments, holds certain risks. While the risk is often minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and strokes, which occur at a rate of 1 in 2 million people, have been associated with chiropractic adjustments. I do not expect the doctor to be able to anticipate all risks and complications and I wish to rely on the doctor to exercise judgment during the course of treatment which the doctor feels, based upon the facts then known, is in my best interest.

I confirm that I have an opportunity to discuss with the doctor or office staff the nature and purpose of chiropractic care and treatments. I have read, or have had read to me, the above consent and have had the opportunity to ask questions about its content. By signing below, I agree to chiropractic treatment as recommended by the doctor. I intend this consent form to cover the entire course of treatment for my present condition(s) and for any future condition(s) for which I seek treatment.

Print Patient's Name

Patient Signature

Date

Below to be completed by patient's representative, if necessary (Patient is a minor or is incapable of completing form)

Print Representative's Name

Representative's Signature

Relationship to patient

NOTICE OF PRIVACY PRACTICE

I have read the Patient Privacy Notice, included with this paperwork and also located in the notebook in the waiting room. 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 any time in the future and will make the new provisions effective for all information that it maintains past and present. I am aware that a more comprehensive version of this "Notice" is available to me and copies are kept in the waiting room and at the front desk. At this time, I do not have any questions about my rights or any of the information I have received.

Print Patient's Name

Patient Signature

Date

Below to be completed by patient's representative, if necessary (Patient is a minor or is incapable of completing form)

Print Representative's Name

Representative's Signature

Relationship to patient

Staff Will Fill Out Section Below if Patient's Signature Not Obtained

Our office made a good faith effort to obtain Acknowledgement of Receipt of our Notice of Privacy Practices, but it could not be obtained for the following reason:

_____ Patient refused to sign.

_____ Emergency situation kept us from obtaining the patient's signature.

_____ Language barriers kept us from obtaining the patient's signature.

_____ Other: _____

Staff Name

Staff Signature

Date

Insurance Information

Do You Currently Have Insurance? *(Please circle)* Yes No

Name of Insurance Company: _____

Insurance Policy Number: _____

*Please Provide Us With Your Card So That We Can Make A Copy
You Will Also Be Asked For A Photo ID*

Date of Birth: _____

Are You The Primary Policyholder On This Card? *(Please circle)* Yes No

If No, List The Name Of The Primary Card Holder: _____

Primary Cardholder's Date of Birth: _____

Do You Have Secondary or Supplemental Insurance? *(Please circle)* Yes No

Name of Insurance Company: _____

Insurance Policy Number: _____

*Please Provide Us With Your Card So That We Can Make A Copy
You Will Also Be Asked For A Photo ID*

Date of Birth: _____

Are You The Primary Policyholder On This Card? *(Please circle)* Yes No

If No, List The Name Of The Primary Card Holder: _____

Primary Cardholder's Date of Birth: _____

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455-A Old Trolley Road~Summerville~SC~29485

ASSIGNMENT OF BENEFITS FOR DIRECT PAYMENT TO DOCTOR

I hereby instruct and direct the payment of all chiropractic benefits allowable and otherwise payable to me under my current insurance policy to Foundation Family Chiropractic, a payment for services rendered. This is a direct assignment of my rights and benefits under this policy. This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said service charges. If my current policy prohibits direct payment to my doctor, then I hereby also instruct and direct you to make the check out to me and mail it to the following address:

Dr. Kyle Heimer, D.C.
Foundation Family Chiropractic
455-A Old Trolley Road
Summerville, SC 29485

Print Patient's Name

Patient Signature

Date

Below to be completed by patient's representative, if necessary (Patient is a minor or is incapable of completing form)

Print Representative's Name

Representative's Signature

Relationship to patient