



PEDIATRIC PRACTICE MEMBER QUESTIONNAIRE

T 1 2 3 _____ / _____

CONFIDENTIAL PRACTICE MEMBER INFORMATION

Child's Name:	Parent/Guardian Name(s):	Date:
Street Address:	City, State, Zip:	Sex: <input type="radio"/> M <input type="radio"/> F
Cell Phone:	Appointment Reminders: <input type="radio"/> Text <input type="radio"/> Email	Cell Carrier:
Email:	Child's SS#:	Birthdate:
How did you hear about us?		Weight:
Who is their 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(s) first begin?	How did the problem start? <input type="radio"/> Suddenly <input type="radio"/> Gradually <input type="radio"/> Post-Injury
Has your child received care for this problem before? <input type="radio"/> Yes <input type="radio"/> No - If yes, please explain:	
Is this condition: <input type="radio"/> Getting Worse <input type="radio"/> Improving <input type="radio"/> Intermittent <input type="radio"/> Constant <input type="radio"/> 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?
1. _____
2. _____
3. _____

PREGNANCY & FERTILITY HISTORY

Please tell us about the pregnancy with this child	
Any fertility issues? <input type="radio"/> Yes <input type="radio"/> No If yes, please explain:	Any notable episodes of mental/physical stress during the pregnancy?
Did mother smoke? <input type="radio"/> Yes <input type="radio"/> No If yes, how many per week?	
Did mother drink? <input type="radio"/> Yes <input type="radio"/> No If yes, how many per week?	
Did mother exercise? <input type="radio"/> Yes <input type="radio"/> No If yes, please explain:	Any other concerns/notable remarks about your child's conception/pregnancy?
Was mother ill? <input type="radio"/> Yes <input type="radio"/> No If yes, please explain:	
Any ultrasounds? <input type="radio"/> Yes <input type="radio"/> No If yes, please explain:	

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LABOR & DELIVERY HISTORY

Child's birth was: Natural vaginal birth Scheduled C-Section Emergency C-Section _____

Child's birth was: At home At a birthing center At a hospital Other: _____

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: _____ Child's birth height: _____ APGAR score at birth: _____ APGAR score after 5 minutes: _____

GROWTH & DEVELOPMENT

Is/was your child breastfed? Yes No If yes, how long? _____

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

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, feet stiff, or bang their head? Yes No

- If yes, please explain: _____

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 their lifetime, including the year: _____

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

- If yes, please list any vaccination reactions: _____

Has your child received any antibiotics? Yes No

- If yes, how many times? Please 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 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

Parent/Guardian Signature: _____ Date: _____



PRACTICE MEMBER REVIEW OF SYSTEMS

THE NERVOUS SYSTEM CONTROLS AND COORDINATES ALL
ORGANS & STRUCTURES OF THE HUMAN BODY



REGIONS	FUNCTIONS	SYMPTOMS	
Cervical	<ul style="list-style-type: none"> • Autonomic Nervous System • ENT System • Vision, Balance, & Coordination • Speech • Immune System • Digestive System • Nerve Supply to Shoulders, Arms & Hands • Metabolism 	<div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p><small>PAST PRESENT</small></p> <input type="checkbox"/> Colic & Excessive Crying <input type="checkbox"/> Ear & Sinus Infections <input type="checkbox"/> Allergies & Congestion <input type="checkbox"/> Immune Deficiency <input type="checkbox"/> Headaches & Migraines <input type="checkbox"/> Vertigo & Dizziness <input type="checkbox"/> Sore Throat & Strep <input type="checkbox"/> Swollen Tonsils & Adenoids <input type="checkbox"/> Vision & Hearing Issues <input type="checkbox"/> Low Energy & Fatigue <input type="checkbox"/> Difficulty Sleeping <input type="checkbox"/> Pain, Numbness, & Tingling in Arms to Hands </div> <div style="width: 45%;"> <p><small>PAST PRESENT</small></p> <input type="checkbox"/> Epilepsy & Seizures <input type="checkbox"/> Sensory & Spectrum <input type="checkbox"/> ADD / ADHD <input type="checkbox"/> Focus & Memory Issues <input type="checkbox"/> Anxiety & Stress <input type="checkbox"/> Balance & Coordination <input type="checkbox"/> Speech Issues <input type="checkbox"/> TMJ / Jaw Pain <input type="checkbox"/> Stiff Neck & Shoulders <input type="checkbox"/> Depression <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Poor Metabolism & Weight Control </div> </div>	
Upper Thoracic	<ul style="list-style-type: none"> • Upper G.I. • Respiratory System • Cardiac Function 	<div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p><small>PAST PRESENT</small></p> <input type="checkbox"/> Reflux / GERD <input type="checkbox"/> Chronic Colds & Cough <input type="checkbox"/> Asthma </div> <div style="width: 45%;"> <p><small>PAST PRESENT</small></p> <input type="checkbox"/> Bronchitis & Pneumonia <input type="checkbox"/> Functional Heart Conditions </div> </div>	
Mid Thoracic	<ul style="list-style-type: none"> • Major Digestive Center • Detox & Immunity 	<div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p><small>PAST PRESENT</small></p> <input type="checkbox"/> Gallbladder Pain / Issues <input type="checkbox"/> Jaundice <input type="checkbox"/> Fever </div> <div style="width: 45%;"> <p><small>PAST PRESENT</small></p> <input type="checkbox"/> Indigestion & Heartburn <input type="checkbox"/> Stomach Pains & Ulcers <input type="checkbox"/> Blood Sugar Problems </div> </div>	
Low Thoracic	<ul style="list-style-type: none"> • Stress & Response • Filtration & Elimination • Gut & Digestion • Hormonal Control 	<div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p><small>PAST PRESENT</small></p> <input type="checkbox"/> Behavior Issues <input type="checkbox"/> Hyperactivity <input type="checkbox"/> Chronic Fatigue <input type="checkbox"/> Chronic Stress </div> <div style="width: 45%;"> <p><small>PAST PRESENT</small></p> <input type="checkbox"/> Allergies & Eczema <input type="checkbox"/> Skin Conditions / Rash <input type="checkbox"/> Kidney Problems <input type="checkbox"/> Gas Pain & Bloating </div> </div>	
Lumbar, Sacrum, & Pelvis	<ul style="list-style-type: none"> • Lower G.I. (Absorption & Motility) • Gut Immune System • Major Hormonal Control 	<div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p><small>PAST PRESENT</small></p> <input type="checkbox"/> Constipation <input type="checkbox"/> Chrohn's, Collitis, & IBS <input type="checkbox"/> Diarrhea <input type="checkbox"/> Bed Wetting <input type="checkbox"/> Bladder & Urination Issues <input type="checkbox"/> Cramps & Menstrual Issues <input type="checkbox"/> Cysts & Endometriosis <input type="checkbox"/> Infertility <input type="checkbox"/> Impotency <input type="checkbox"/> Hemorrhoids </div> <div style="width: 45%;"> <p><small>PAST PRESENT</small></p> <input type="checkbox"/> Sciatica & Radiating Pain <input type="checkbox"/> Lumbopelvic / SI Joint Pain <input type="checkbox"/> Hamstring Tightness <input type="checkbox"/> Disc Degeneration <input type="checkbox"/> Leg Weakness & Cramps <input type="checkbox"/> Knee, Ankle, & Foot Pain <input type="checkbox"/> Weak Ankles & Arches <input type="checkbox"/> Lower Back Pain <input type="checkbox"/> Gluten & Casein Intolerance <input type="checkbox"/> Poor Circulation & Cold Feet </div> </div>	

Practice Member Name: _____ Date: _____



POLICIES AND FEE SCHEDULE

- **Consultation** - includes patient history and current health concerns.
- **Assessment (*new or established patient*)** - Includes one or more of the following:
thermography, surface electromyography, range of motion, motion and/or static palpation, leg check, postural assessment, vital signs.
- **Chiropractic Adjustment** - the actual re-alignment of the vertebrae done by hand or instrument. Often a sound will be heard, but if there is no auditory result, it does not mean that the adjustment has not taken place.

RELEASE OF AUTHORIZATION / ASSIGNMENT OF BENEFITS

I authorize and request payment of insurance benefits directly to Dr. Joseph Schmitt, DC. I agree that this authorization will cover all services rendered until I revoke the authorization. I agree that a photocopy of this form may be used in place of the original. All professional services rendered are charged to the patient. It is customary to pay for services when rendered unless other arrangements have been made in advance. I understand that I am financially responsible for charges not covered by this assignment.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that I have certain rights of privacy regarding my protected health information, under the health insurance portability and accountability act of 1996 (HIPAA). I understand that this information can and will be used to:

1. Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third-party payers.
3. Conduct a normal healthcare operations, such as quality assessments and physicians certifications.

I acknowledge I may request your NOTICE OF PRIVACY PRACTICES containing a more complete description of the uses and disclosures of my health information. I also understand I may request, in writing, that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operation. I also understand you are not required to agree with my requested restrictions, but if you agree you are bound to abide by such restrictions.

PRACTICE MEMBER'S SIGNATURE

DATE



TERMS OF ACCEPTANCE

In order to provide for the most effective healing environment, most effective application of chiropractic procedures, and the strongest possible doctor-patient relationship, it is our wish to provide each patient with a set of parameters and declarations that will facilitate the goal of optimum health through chiropractic. To that end, we ask that you would acknowledge the following points regarding chiropractic care in the services that are offered through this clinic:

- A. Chiropractic is a very specific science, authorized by law to address spinal health concerns and needs.
- B. Chiropractic seeks to maximize the inherent healing power of the human body by restoring normal nerve functions through the adjustment of the spinal subluxation(s). Subluxations are deviations from the normal spinal structures and configurations that interfere with normal nerve processes.
- C. The chiropractic adjustment process, as defined in the law of this jurisdiction, involves the application of a specific directional thrust to a region or regions of the spine with a specific intent of positioning misaligned spinal segments. This is a safe, effective procedure applied over 1 million times each day by Doctors of Chiropractic in the United States, alone.
- D. A thorough chiropractic examination and evaluation is part of the standard chiropractic procedure. The goal of this process is to identify any spinal health problems and chiropractic needs. If during this process, any condition or question outside the scope of chiropractic is identified, you will receive a prompt referral to an appropriate provider or specialist, according to the initial indicators of need.
- E. Chiropractic does not seek to replace or compete with your medical, dental, or other types of health professionals. They retain responsibility for care and management of medical conditions. We do not offer advice regarding treatment prescribed by others.
- F. Your compliance with care recommendations, home and self-care, etc., is essential to maximum healing in optimal health through chiropractic.
- G. We invite you to speak frankly to the doctor on any matter related to your care at this facility, its nature, duration, or cost. We work to maintain as a supporting, open environment.

By my signature below, I have read and fully understand the above statements. All my questions regarding the doctors objectives pertaining to my care in this office have been answered to my satisfaction. I, therefore, accept chiropractic care on this basis.

PRACTICE MEMBER'S SIGNATURE

DATE



INFORMED CONSENT FOR CHIROPRACTIC CARE

Chiropractic care, like all forms of healthcare, while offering considerable benefits may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases, injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include: sprain/strain injuries, irritation of a disc condition, and rarely, fractures. Prior to receiving chiropractic care in this chiropractic office, a health history and physical examination will be completed. These procedures are performed to assess your specific conditions, your overall health, and in particular your spinal health. These procedures will assist us in determining if chiropractic care is needed, or if any further examination or studies are needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with care recommendations prior to beginning care.

I understand and accept there are risks associated with chiropractic care. I give consent to the examination and the chiropractic care the doctor deems necessary, including spinal adjustments, as reported following my assessment.

PRINT PRACTICE MEMBER'S NAME

PRACTICE MEMBER'S SIGNATURE

DATE

If a practice member is a minor/child, parent or guardian must sign below.

SIGNATURE OF PRACTICE MEMBER/GUARDIAN

DATE

RELATIONSHIP TO MINOR

WITNESS SIGNATURE (*office staff*)

DATE
