FOUNDATION
CHIROPRACTIC

16730 N. Marketplace Blvd.
Nampa, ID 83686
208.466.4600

CHILD NEW PATIENT QUESTIONNAIRE (0-12 years)

**PLEASE COMPLETE EVERY SECTION OF THE INTAKE FORM. IF SOMETHING DOES NOT APPLY TO YOU, USE "N/A."
IF ANY SECTIONS OF THE INTAKE ARE INCOMPLETE, WE MAY NEED TO RESCHEDULE YOUR NEW PATIENT EXAM.**

Child Information:

Child's Name _____ Date _____

Parent(s) Names

_____

Date of Birth _____m/_____d/_____y Gender: ◯ Male ◯ Female

Siblings' Names and Ages

_____

Address _____ City/Town _____ Postal Code _____

Parent's E-mail Address

_____

Mobile # _____ Home # _____ Business # _____

Best time to contact you? _____

Whom may we thank for referring your child to this office? _____

Circle the phrase that most represents your child's reason for care:

◯ Wellness ◯ Prevention ◯ Feel good ◯ Symptom Relief

Reason for your child seeking services at our office: _____

Has your child ever seen a Chiropractor? If yes, who? Date of last visit: _____

Name & Address of Obstetrician/ Midwife:

_____

Name & Address of Primary Health Care Provider:

_____

Date of last visit _____ Purpose of visit _____

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Health Concerns

Please list your child's health concerns according to their severity:

Concern	Rate of Severity 1=mild, 10=worst	When did it start? For how long?	If you had the condition before, when?	Did the problem begin with an injury?	What % of time is pain present?
1.					
2.					
3.					

Pregnancy and Birth History

Gestational Duration: _____ weeks

PHYSICAL STRESS

Trauma/Falls during pregnancy_____

Any ultrasounds or other radiation? ◯ Yes ◯ No

How many and for what reasons? _____

Invasive Procedures (e.g. Amniocentesis, CVS) ? ◯ Yes ◯ No

CHEMICAL STRESS

During the pregnancy did the mother:

Smoke? ◯ Yes ◯ No How much? _____

Drink Alcohol? ◯ Yes ◯ No How much? _____

Prescription Medications? ◯ Yes ◯ No How much? _____

Recreational Drugs? ◯ Yes ◯ No How much? _____

Fall ill during pregnancy? ◯ Yes ◯ No Please explain _____

Were any supplements taken during the pregnancy? ◯ Yes ◯ No

Please list: _____

EMOTIONAL STRESS

Please rate your stress levels during pregnancy 1-10 (1= low, 10=high):_____

LABOR

Was labor induced? ◯ Yes ◯ No

Duration of labor? _____

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Duration of active (pushing stage) labor?_____

Did mother receive medications? ◯ Yes ◯ No

If yes, which: _____

BIRTH

Type of birth? ◯ Vaginal: Cephalic (head first) ◯ Breech (feet first) ◯ C-Section

Location of birth? ◯ Home ◯ Hospital ◯ Birthing center

Birth Assistants? ◯ Midwife ◯ Doula ◯ Obstetrician

Was there any assistance needed during birth?

◯ Forceps ◯ Cesarean ◯ Vacuum Extraction ◯ Induction ◯ Assisted Traction/Head Turning

Was delivery considered normal? ◯ Yes ◯ No

Were there complications during birth? ◯ Yes ◯ No

Please explain:

_____

Was there any evidence of birth trauma to the infant? Check all that apply:

◯ Bruising ◯ Odd shaped head

◯ Stuck in birth canal ◯ Fast or excessively long birth

◯ Respiratory depression ◯ Cord around neck

Was your child subjected to any of the following? Check all that apply:

◯ Silver nitrate drops in eyes Incubation How long? _____

◯ Vitamin K shot Separation from you How long? _____

◯ Hepatitis shot

Did your child spend any time in intensive care? Yes No If yes, how long? _____

APGAR score at birth? _____ APGAR score at 5 minutes? _____

Birth Weight? _____ Birth Length? _____

Childhood History

PHYSICAL STRESS

Does your child have a preferred sleeping position? ◯ Yes ◯ No _____

Did your child prefer one-sided breast-feeding position? ◯ Yes ◯ No _____

Did your baby spit up after feeding? ◯ Yes ◯ No _____

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Any falls or injuries down stairs, bicycle etc? ◯ Yes ◯ No _____

Does the child ever bang his/her head repeatedly? ◯ Yes ◯ No _____

Any traumas resulting in bruises, fractures, stitches? ◯ Yes ◯ No _____

Any hospitalizations or surgeries? ◯ Yes ◯ No _____

Please list all surgeries your child has had:
1. Type _____ When _____ Doctor _____

2. Type _____ When _____ Doctor _____

Please list any accidents and/or injuries: auto, sports, or other (Especially those related to your child's present problems).
1. Type_____ When_____ Hospitalized? ◯ Yes ◯ No

2. Type_____ When_____ Hospitalized? ◯ Yes ◯ No

Have you ever had x-rays taken? ◯ Yes ◯ No When?_____ Where?_____

What area of your child's body:_____

Does your child play sports? ◯ Yes ◯ No _____

If yes, hours per week? _____ Age when the child began? _____

Is a school backpack used? ◯ Yes ◯ No Weight of backpack? _____lbs

Approximate hours spent at play per week? _____

Average time spent at computer/TV/video games per week? _____ hrs

Does your child wear glasses or contact lenses? ◯ Yes ◯ No _____

Does your child have trouble reading the board? ◯ Yes ◯ No _____

Does your child have difficulty with coordination? ◯ Yes ◯ No _____

CHEMICAL STRESS

Was/is the child breast-fed? ◯ Yes ◯ No For how long? _____

At what age was:

Formula introduced? _____ Brand? _____

Cow's milk introduced? _____

Solid food? _____

Food/juice intolerance? ◯ Yes ◯ No_____

Does your child have food allergies? ◯ Yes ◯ No_____

What is your child's favorite food? _____

What does your child regularly drink? _____

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The type of diet your child usually follows is classified as: _____

Please mark any dietary selection that is appropriate for your child, by grade according to the following scale:

Daily:
D - Consume this daily
FD - Consume this a few times per day

Monthly:
M - Consume this monthly
FM - Consume a few times per month

Weekly:
W - Consume this weekly
FW - Consume this a few times per week

Never:
O - Do not consume this

Eggs_____ Fasting _____ Fruit _____ Fried Foods_____ Seafood_____ Refined Sugar _____

Fish _____ Diet Food _____ Organic Foods _____ Cooked vegetables_____ Dairy _____

Coffee _____ Beef _____ Weight Control Diet _____ Raw Vegetables_____ Canned/Frozen vegetable __

Soft Drink_____ Poultry_____ Artificial Sweetener _____ Whole Grains_____

Does your child have a bowel movement every day? ◯Yes ◯No _____

Does your child have regular or occasional skin rashes? ◯Yes ◯No _____

What vaccinations were given and at what age?

_____

_____

Reason for vaccinations _____

Were there any negative reactions? ◯ Yes ◯ No _____

Was there any:

◯ Fever ◯ Inconsolable crying ◯ Irritability ◯ Arching of body ◯ Drowsiness

◯ Bowel disturbances ◯ Feeding disturbances ◯ Other: _____

History of antibiotics? ◯ Yes ◯ No

If so, how many courses of antibiotics has your child received in their lifetime? _____

Reason and length of last course of antibiotics? _____

Please list ALL medications your child currently takes or has taken in the past 6 months:

Name _____ Dosage _____ For what? _____

Name _____ Dosage _____ For what? _____

Name _____ Dosage _____ For what? _____

Please list all nutritional supplements, vitamins, homeopathic remedies your child presently takes:

Name _____ For what? _____

Name _____ For what? _____

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Are there pets in the home? ◯ Yes ◯ No _____

Are there any smokers at home? ◯ Yes ◯ No _____

EMOTIONAL STRESS

Did mother have any difficulties with breast-feeding?

Did mother and baby have difficulty bonding?

Did the mother experience any postpartum depression?

Night terrors, sleep walking, difficulty sleeping ◯ Yes ◯ No _____

Do you consider their sleeping pattern normal? ◯ Yes ◯ No _____

Quality of Sleep? ◯ Good ◯ Fair ◯ Poor Number of hours _____

Behavior problems? ◯ Yes ◯ No _____

Do you feel that your child's social and emotional development is normal for their age? ◯ Yes ◯ No

Does your child attend daycare? ◯ Yes ◯ No From what age? _____

GROWTH AND DEVELOPMENT

Was your child alert & responsive within 12 hours of delivery? ◯ Yes ◯ No

If no, please explain: _____

At what age did your child:

Respond to sound? _____ Sit alone? _____

Follow an object? _____ Teethe? _____

Hold their head up? _____ Crawl? _____

Vocalize? _____ Walk? _____

FAMILY HISTORY

Describe any medical family history on mother's side: (e.g. cancer, diabetes etc)

_____

On father's side:

_____

Do any of their sibling's have any health concerns? ◯ Yes ◯ No

If yes, please describe: _____

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Informed Consent to Chiropractic Care

When a person seeks chiropractic care, it is essential for both the individual and the chiropractor to be working towards the same objective.

Chiropractic care has one goal, to correct vertebral subluxations. It is important that each person understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Health: A state of optimal physical, mental, and social wellbeing, not merely the absence of symptoms.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebrae in the spinal column which causes alteration of the nerve function and interference to the transmission of mental impulses, resulting in a decrease in the body's innate ability to express its maximum health potential.

Adjustment: An adjustment is a specific application of forces to facilitate the body's correction of a vertebral subluxation. Our method of correction is by specific adjustments of the neuro-spinal system.

I understand that my care at this office will be focused on the detection and correction of vertebral subluxations. I hereby request and consent to the performance of chiropractic adjustments and assessments. Understanding that everybody has a different potential for wellness thus, the maximal results I will receive in this office cannot be predicted or guaranteed.

Chiropractic care is considered to be one of the safest and most effective forms of care. I understand and am informed that, unlike many other health care professions, the risks associated in receiving chiropractic care are extremely minimal. In recent years there have been rare incidents of injury to the vertebral artery during the course of care by medical doctors, physiotherapists and chiropractors. To put this in perspective, the risk of stroke in the general population is 0.00057%. The risk of stroke after a chiropractic adjustment is 0.00025%. The risk of death from taking an aspirin and/or other anti-inflammatory drugs is 0.04%.

It is not our goal or intention to diagnose, treat or attempt to cure any physical, mental, emotional symptoms. Our expertise is in health, wellness, healing and human physiology. However, if during the course of chiropractic care, we encounter unusual findings, we will bring these to your attention. 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. Please discuss care alternatives with our chiropractors.

Our primary goal is to release life in the body, through the detection and correction of vertebral subluxations.

At this office, the privacy of your personal information is an essential part of our office providing you with quality care. We are committed to collecting, using and disclosing your personal information responsibly. Our office has a privacy policy that complies with federal law, which you may view at any time by asking our staff.

I, _____ have read and fully understand the above statements.
(PRINT NAME)

I have also had an opportunity to ask questions about its content. I therefore accept chiropractic assessments and care on this basis. I intend this consent form to cover the entire course of my care with Foundation Chiropractic and the attending chiropractors.

_____ _____
(PATIENT/GUARDIAN SIGNATURE) (DATE)

_____ _____
(FC REPRESENTATIVE SIGNATURE) (DATE)

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HIPAA

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information with authorization is strictly limited to defining situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purpose of treatment, payment or practice operations will be made without obtaining your consent. You may request restrictions on your disclosures. You may inspect and receive copies of records within 30 days of a request. You may request to view charges to your records. In the future, we may contact you for an appointment reminder, announcements, and inform you about our practice and its staff.

I understand that, under the *Health Insurance Portability and Accountability Act of 1996 (HIPAA)*, 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 with multiple healthcare providers who may be involved in that treatment directly or indirectly, obtain payment from third party payers, and conduct normal healthcare operations such as quality assessments and physician's certificates. I also understand that I can request, in writing, that you restrict how my personal information is used and disclosed.

I, _____ have read and fully understand the above terms of acceptance and

hereby grant permission for my child_____ to receive a chiropractic assessment and chiropractic care.

Photo and Video Release

I,_____, hereby grant permission to **Foundation Chiropractic** to use photographs and/or video
Parent or guardian name
recordings of my child _____, for the purpose of social media and in-office use.
Child's name
I understand that these photographs and/or video recordings may be used in aiding the education and varieties of treatments offered to minors, including but not limited to, the company's website, social media pages and in office testimonials. I certify that I am the parent or legal guardian of the minor and have the right to authorize the use of their image and or treatment videos.

Signed: _____ Date: _____