EXPERIENCE life CHIROPRACTIC

Pediatric Questionnaire

CONFIDENTIAL INFORMATION

Child's Name: Parent/Guardian Name(s): Date:

Street Address: City, State, Zip

Phone: Email:

Child's SS#: Birthdate: Age: Sex: M F Height:

How did you hear about us? Weight:

Who is your primary care physician?

Is your child receiving care from any other health professionals? Yes 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 concern(s) bring your child to be evaluated by a chiropractor ?

When did the concern(s) first begin?

How did the challenge start? Suddenly Gradually Post-Injury

Has your child ever received care for this concern before? Yes No

Is this concern: Getting worse Improving Intermittent Constant Unsure

What makes the challenge better?

What makes the challenge worse?

HEALTH GOALS FOR YOUR CHILD

What are your top three health goals for your child:

1. _____

2._____

3._____

PREGNANCY & FERTILITY HISTORY

Please tells 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 birth was : Vaginal birth Scheduled C-section Emergency C-section At how many weeks was your child born?

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

Please circle any applicable interventions or other 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 mins:

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 TV, computer, tablet or phone?

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

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NOTICE OF PRIVACY POLICY

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment or practice operations will be made only after obtaining your consent.

- You may request restrictions on your disclosure.
- You may inspect and receive copies of your records within 30 days with a request.
- You may request to view changes to your records
- In the future, we may contact you for appointment reminders, announcements and to 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 regular 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
- Conduct normal healthcare operations such as quality assessments and physician's certifications

I have read and understand your Notice of Privacy Practices. A more complete description can be requested. I also understand that I can request, in writing, that you restrict how my personal information is used and/or disclosed.

Patient Name (printed):	Relationship to Patient:
Signature:	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 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 knowledgably 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 of 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 subluxations. **Vertebral subluxation** is a disturbance in 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.

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, 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. I UNDERSTAND THE INFORMATION PROVIDED. ALL QUESTIONS I HAVE ABOUT THIS INFORMATION HAVE BEEN ANSWERED TO MY SATISFACTION. HAVING THIS KNOWLEDGE, I KNOWINGLY ATHORIZE DR. SHEENA NAGELI TO PROCEED WITH CHIROPRACTIC CARE DATED THIS _____ DAY OF _____ 20_____.

Parental Consent For a Minor Patient:

Patient Name:	**Patient Age:**	**DOB:**
Printed name of person legally authorized to sign for patient:		
Signature:	**Relationship to patient:**	