Pediatric Health Questionnaire

All information you supply is confidential. We comply with all federal privacy standards.

Name_____ Home Phone_____

Address_____ Cell Phone _____

City, State, Zip _____ E-mail Address_____

Birth date_____ Age_____ Grade_____

Primary Doctor_____ Phone #_____

Would you like us to send your family doctor a copy of your child's chiropractic health records? □ Yes □ No

Contact in case of emergency_____ Phone #_____

Preferred method of contact: □ Text Message □ Email □ Cell Phone □ Home Phone

How did you hear about our office?_____

YOU MUST COMPLETE ALL OF THE FOLLOWING SECTIONS TO THE BEST OF YOUR ABILITY!!

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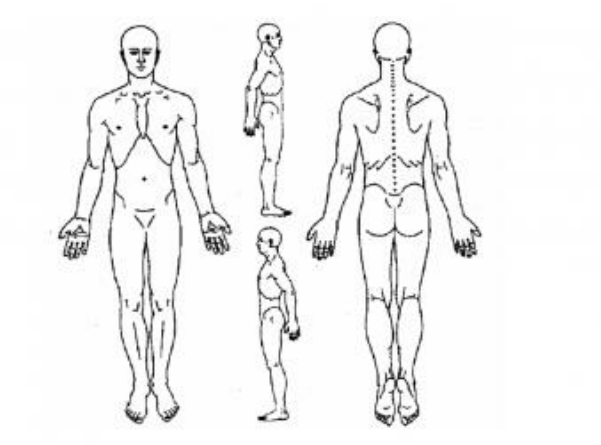
CHIEF COMPLAINT:



Where is the Child's Pain: _____
(please ALSO mark on the diagram where they are experiencing pain)

Does the Pain Travel Down Arms or Legs? Y N
□ Shoulder □ Arm □ Hand □ Buttocks □ Legs □ Feet

Duration and Timing:
When did the symptoms start?_____
How did they start?_____

How often does it occur?
□ Occasional (25% or less) □ Intermittent (26-50%)
□ Frequent (51-75%) □ Constant (76-100%)

Rate Their Current Pain: None = 0 1 2 3 4 5 6 7 8 9 10 = Most Severe

Quality of Symptoms: (What does it feel like?)
□ Aching □ Burning □ Catching □ Cramps □ Dull □ Nagging □ Numbness □ Pinching □ Sharp □ Shooting □ Sore
□ Stabbing □ Stiffness □ Tight □ Tingling □ Tired/Weak □ Throbbing

What makes the problem BETTER?
□ Nothing □ Heat □ Ice □ Inactivity/Rest □ Lying Down □ Movement/exercise □ Pain medication □ Sitting
□ Standing □ Stretching □ Walking □ Other:_____

What makes the problem WORSE?
□ Nothing □ Bending □ Coughing/Sneezing □ Inactivity □ Lifting □ Lying down □ Movement/exercise □ Reaching
□ Sitting □ Standing □ Twisting/ Turning □ Walking □ Other:_____

Prior Treatment (What have you done to relieve symptoms)
□ Acupuncture □ Heat □ Ice □ Massage □ Over the counter drugs □ Prescription Medications
□ Physical Therapy □ Chiropractic—Who have you seen: __ □ Other: _____

Previous Treatment for Pain Performed by:
Y N Family MD/DO Name:_____ Y N Physical Therapist Name:_____
Y N Chiropractor Name:_____ OTHER:_____

Diagnostic Tests Performed:
Y N X-rays Date:_____ Y N Bloodwork/Labs Date:_____
Y N CT scan Date:_____ OTHER:_____

Past Medical History

- ***Research shows that spinal problems often begin at birth.***
  - Has your child ever been to a chiropractor before? Yes No
  - How old was your child when they received their first chiropractic checkup? _____ Most recent visit? _____

- ***Difficult, long and/or doctor-assisted births can cause spinal misalignments.***
  - What delivery method was used when your child was born (Please circle):
    vaginally C-section forceps suction cup other device_____
  - My child was born at (Please circle): Home Hospital Birthing Center Other:_____
  - How long was the actual labor and delivery time? _____

- ***Have you ever been told that your child has a spinal curvature, spinal arthritis, or inherited spinal problem?***
  Yes No If so, what? _____

- ***Poor posture leads to poor health and often indicates a spinal problem.***
  - How would you rate your child's posture? Poor - 1 2 3 4 5 6 7 8 9 10 - Excellent

- ***Did your child have early health challenges such as colic or frequent ear infections?***
  - (Please Circle) Yes / No Currently / In the Past

- ***Does your child suffer from any of the following*** **(Please circle):**
  Allergies Sinus Problems Bed-Wetting Difficulty Concentrating ADD or ADHD Ear Infections Headaches
  Seizures Colic Chronic Colds Fevers Asthma

- ***Does your child have other health problems that concern you?*** _____
  _____

- ***Prescription medications may cause various side effects, hide the severity of health problems and hinder the body's ability to heal.***
  - What medications is your child currently taking?_____
    _____
  - How many prescriptions of antibiotics has your child taken during the past 6 months?_____ During their lifetime?_____

- ***Falls, sports impacts, head traumas, bike/4wheeler accidents, trampolines, and auto accidents can cause serious spinal problems.***
  - Is this visit related to an auto accident or injury? Yes No Date of Incident _____

- ***According to the National Safety Council, approximately 50% of infants fall head first from a high place (bed, changing table, high chair, stairs, etc.) during the first year of life.*** Has this happened to your child? Yes No

- ***Which contact sports does your child play?*** **(Please circle)**
  Soccer Football Gymnastics Karate Dance Motocross Skiing
  Hockey Baseball Basketball Other_____

*****Please provide us with a copy of your health insurance card so we can verify any coverage and if you may be eligible for reimbursement from them.*****

How will you be paying for today's visit: (circle one) Cash Check Credit Card

We are Out of Network providers for all Healthcare Insurance Companies, with the exception of Novitas Medicare- Part B. What an Out of Network provider means is that we do not have an agreement or contract with that insurance company. Because our doctors are Out of Network providers, we require all our patients to pay at the time of service. As a courtesy to all our patients, we will verify your insurance coverage and send your visits/claims to your specific insurance company. If there is any reimbursement for your care, your insurance company will send any such payment and/or correspondence directly to you/policy holder.

For Patients who have Novitas Medicare - Part B coverage, adjustments may be considered for insurance coverage depending upon patient's deductible, diagnosis and frequency. If additional therapies are needed, Novitas Medicare- Part B will not consider them for coverage, only the chiropractic adjustment.

Parent/Guardian Initials:_____

The above information is true and accurate to the best of my knowledge. I understand that all fees are due and payable at the time of service.

Parent/Guardian Signature_____ Date _____