Optimal Health
Chiropractic & Wellness Care

Pediatric Questionnaire

Confidential Patient Information

Child's Name:_____ Parent/Guardian Name(s):_____
Street Address:_____ City/State/Zip:_____
Cell Phone:_____ Other Phone:_____ Child's Sex: **M / F**
Email:_____ Child's SS#:_____ Birthdate:_____ Age:___
How did you hear about us?_____ Weight:_____ Height_____
Who is your primary care physician?_____
Is your child receiving care from any other health professionals? **Y / N**
If yes, please provide their name and 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? **Y / N**
If yes, 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 goals for your child?
1._____
2._____
3._____

What would you like to gain from chiropractic?
_____Resolve existing condition
_____Overall Wellness
_____Both

Pregnancy & Fertility History

Please tell us about your pregnancy
Any fertility issues? **Y / N** If yes, explain:_____
Did mother smoke? **Y / N** If yes, how many per week?_____
Did mother drink? **Y / N** If yes, how many per week?_____
Did mother exercise? **Y / N** If yes, explain:_____
Was mother ill? **Y / N** If yes, explain:_____
Any ultrasounds? **Y / N** If yes, explain:_____
Please explain any notable episodes of mental of physical stress during your pregnancy:_____
Please explain any other concerns or notable remarks about your child's conception or pregnancy:_____

Labor and Delivery History

At how many weeks was your child born?_____Doctor/Obstetrician's Name:_____
Child's birth was: **Natural Vaginal Birth / Scheduled C-section / Emergency C-section**
Please check any applicable interventions or complications:
___Breech ___Induction ___Pain meds ___Epidural ___Episiotomy ___Vacuum Extraction ___Other:_____
Please describe any other concerns or notable remarks about your child's labor and/or delivery:_____

_____

Birth weight:_____ Birth height:_____ APGAR score at birth:_____ APGAR after 5 minutes:_____

Growth & Development History

Is/was your child breastfed? **Y / N** If yes, how long?_____ Difficulty with breastfeeding? **Y / N**
Did they ever use formula? **Y / N** If yes, at what age?_____ If yes, what type?_____
Did/does your child ever suffer from colic, reflux, or constipation as an infant? **Y / N**
If yes, please explain:_____
Did/does your child frequently arch their neck/back, feel stiff, or bang their head **Y / N**
If yes, please explain:_____
At what age did the child: Respond to sound:_____ Follow an object:_____ Hold their head up:_____ Teethe:_____
Vocalize_____ Sit alone:_____ Crawl:_____ Walk_____ Begin solid foods_____ Begin cow's milk _____
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? **Yes (on schedule) / Yes (delayed schedule) / No**
If yes, please list any vaccine reactions:_____

_____
Has your child received any antibiotics: **Y / N**
If yes, how many times and list reason:_____
Night terrors or difficulty sleeping? **Y / N** If yes, please explain:_____
Behavioral, social, or emotional issues: **Y / N** If yes, explain:_____
How many hour 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 / Average / Mostly processed foods**

Acknowledgement and Consent

Patient's Name_____
Parent/Guardian (Print)_____
Parent/Guardian (Sign)_____ Today's Date_____

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INFORMED CONSENT FORM

PATIENT NAME:_____ DATE: _____

To the patient: Please read this entire document prior to signing it. It is Important that you understand the information contained in this document. If anything is unclear, please ask questions before you sign.

The nature of the chiropractic adjustment:

The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical Instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis / Examination/ Treatment

As a part of the analysis, examination, and treatment. you are consenting to the following procedures:

- spinal manipulative therapy
- range of motion testing
- muscle strength testing
- pressure wave medical wave
- radiographic studies
- whole body vibration
- palpation
- orthopedic testing
- postural analysis testing
- hot/cold therapy
- mechanical traction
- extremity manipulative therapy
- vital signs
- basic neurological
- myofascial release
- electrical stim
- cold laser therapy
- TENS units

Other:_____

The material risks inherent in chiropractic adjustment:

As with any healthcare procedure, there an, certain complications which may arise during chiropractic manipulation and therapy. These complications, though ***extremely rare,*** include but are not limited to fractures, there have been reports of disc injuries although no clinical scientific study has ever demonstrated chiropractic care to be the cause, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations and bums. Some manipulations of the upper spine have been associated with Injury to the arteries in the neck which could cause or contribute to stroke. However, documented cases are exceedingly rare, and it has been estimated by researchers that the probability of a spinal adjustment causing a stroke Is one in several million. Stroke has been the subject of tremendous disagreement and cause is yet to be determined. Some patients will feel some stiffness and soreness following the first few days of treatment.

I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition
that would otherwise not come to my attention, it is your responsibility to inform me.
Overall, compared to other forms of health care, chiropractic is extremely safe, and complications are generally rare.

The risks and dangers attendant to remaining untreated:

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.

I have read the above explanation of the chiropractic adjustment and related treatment. By signing below, I state that Ihave weighed the risks involved in undergoing treatment and have decided that It Is In my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment and extend this consent to Include all Doctors of Optimal Health Chiropractic, PLLC.

Dated:_____ **Printed Name:** _____

Patient Signature (Or Signature of Parent or Guardian): _____

PATIENT NAME:_____ **DATE:**_____

Financial Responsibility:

The privilege of insurance assignment begins when our office has qualified your insurance coverage. For your convenience, Optimal Health Chiropractic will bill your insurance company directly and accept assignment. Your insurance is not a guarantee of payment for services rendered in this office. It is your responsibility to pay any remaining balance with our office and seek reimbursement from your insurance company. Your fees are due and payable at this time of examination, x-rays and treatments are received, unless other arrangements have been made in advance. X-Rays remain property of this clinic.

- All co-payments and deductibles must be paid when services are rendered.
- There will be a $35 fee for all returned checks.
- Balances over 30 days may be subject to additional collection fees.
- All accounts not paid within 90 days will receive final notification and be turned over to a collection agency for further action.
- If the schedule of care is suspended or terminated, all outstanding fees for professional services will be immediately due and payable.

Patient Name: _____ **Signature:** _____

HIPAA Privacy Practices:

I acknowledge that I have received and/or have been given the opportunity to review Optimal Health Chiropractic's Notice of HIPAA Privacy Practices for protected health information.

Patient Name: _____ **Signature:** _____

Consent to treat minor: (Minor's name): _____

Parent/Guardian Signature Authorizing Care: _____

NOTICE OF PRIVACY PRACTICES AVAILABLE UPON REQUEST

I understand and consent to the following appointment reminders that will be used by the Practice: a) postcards or letters mailed to the address I provided; b) phone calls made to the number I have provided and/or voicemails left on an answering machine or with the individual answering the phone; c) emails sent to the email address I have provided.

AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

You may release my health information to the following:

- ☐ **DO NOT RELEASE MY INFORMATION TO ANYONE**
- ☐ **ANYONE WHO REQUESTS IT**
- ☐ **SPOUSE**_____
- ☐ **CHILDREN** _____
- ☐ **FAMILY MEMBER**_____
- ☐ **FRIEND**_____

ATTENTION PATIENT: If no one is checked on this form, we cannot give any information to anyone. If you sign this authorization, you can revoke it later. The exception to this is if we have already acted in accordance with the authorization. If you want to revoke your authorization later, simply send a written note to the office.

Signature:_____ **DATE:**_____