WALLACE FAMILY CHIROPRACTIC

CHILD CHIROPRACTIC HEALTH QUESTIONAIRE

Child's Name:_____Home Phone _____

Parent/Guardian Name: _____

Address: _____

City: _____ State: _____ Zip _____

Parent/Guardian Cell _____ Parent/Guardian Work Phone_____

E-mail Address _____

Child's D.O.B._____ Age _____ Grade _____

1. Spinal problems can cause a variety of health problems. Please circle the health complaint(s) your child is currently experiencing or experiences on a periodic basis:

Neck Pain	Asthma	Frequent Colds	Skin Problems
Back Pain	Allergies	Spinal Curvature	Chronic Fatigue
Headaches	Sinus Problems	Indigestion	ADD/ADHD
Bedwetting	Ear Infections	Arthritis	Other _____

2. What is your child's primary health complaint?_____

3. Research shows that spinal problems often begin at birth. How old was your child when they received their first chiropractic checkup? Never 0-2 years 2-5 years 5-12 years

4. Difficult, long and/or doctor-assisted births can cause spinal misalignments. Was your child born vaginally, by C-section, forceps, suction cup or other device? (Please circle one)

5. How long was the actual labor and delivery time? _____

6. Have you ever been told that your child has a spinal curvature (aka Scoliosis) or inherited spinal problem? YES NO

7. Poor posture can lead to poor health and usually indicates a spinal problem. How would you rate your child's posture?
   Poor - 1 2 3 4 5 6 7 8 9 10 – Very Good

8. Did your child have early health challenges such as colic, irritability or frequent ear infections? YES NO

9. Does your child have other health problems that concern you? _____

10. Do you worry often about your child's health? YES NO

11. Is your child currently taking prescription medication? YES NO If Yes, what kind/How Much? _____

12. Falls, sports impacts and auto accidents can cause serious spinal problems. Is this visit related to a fall, sports impact, auto accident or injury? YES NO Date of Incident _____

13. If Dr. Diann feels that your child will benefit from chiropractic care: (Please check all that apply)
    - ☐ I am willing to follow the Dr.'s recommendations because I strongly value my child's health
    - ☐ I am willing for my child to receive care if payment plans are available
    - ☐ I am willing for my child to receive care but only if insurance pays for all of it
    - ☐ I am not interested in receiving any care for my child at this time

14. How did you hear about our Office? _____

The above information is true and accurate to the best of my knowledge.

Parent/Guardian Signature _____ Date: _____

Wallace Family Chiropractic

AUTHORIZATION FOR CHIROPRACTIC CARE

DATE: _____

I, the undersigned, a patient in this office hereby authorize Dr. Diann Wallace and whomever she may designate as her assistant to administer such examination/care as is necessary, and to perform the following therapy or procedures are as considered necessary on the basis of findings during the said course of examination/care.

I hereby certify that I have read and fully understand the above authorization for chiropractic examination/care, the reasons why the above named examination/care is considered necessary, its advantages and possible complaints, if any, as well as possible alternative modes of examination/care, which were explained to me by Dr. Diann Wallace.

I also certify that no guarantee of assurance has been made as to the results that may be obtained.

SIGNED: _____

Print Name: _____

Wallace Family Chiropractic
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Fax: (856)-494-6777
Tax ID: 82-5359753

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I understand and have been provided with a Notice of Information Practices that Provides a more complete description of information uses and disclosures.
I understand that I have the following right and privileges:

. The right to review the notice prior to signing this consent.
. The right to object to the use of my health information for directory purposes.
. The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or Health care operations.

____ I give my permission to Wallace Family Chiropractic to use my address, phone number and clinical records to contact me with birthday cards, holiday cards, newsletters and information about treatment alternatives or other health related information. I also give permission to put my child's picture up on our "Chiro Kids Corner Wall"

_____ _____
PATIENTS SIGNATURE DATE

_____
PRINT NAME