HarmonizedNeurology
FAMILY CHIROPRACTIC

105 Bulifants Blvd, Ste B
Williamsburg VA 23188
(757) 707-3020
care@harmonizedneurology.com
www.harmonizedneurology.com

Pediatric Patient Questionnaire

1. CONFIDENTIAL PATIENT INFORMATION:

Child's Name _____ Date of Birth _____ Gender _____

Child's Preferred Name _____ Height _____ Weight _____

Parent/Guardian Name(s) _____ Email _____

Street Address _____ Apt/Unit # _____ City _____ State _____ Zip _____

Cell Phone _____ Home Phone _____ Work Phone _____

Who is your primary care physician?

_____

2. How did you hear about us? Please select all that apply.

- ☐ Current Patient (list who)_____
- ☐ Professional Referral/Doctor (list who) _____
- ☐ Community Partner (list who) _____
- ☐ Google Search (what terms did you search?) _____
- ☐ Facebook ☐ Other (please specify)_____

3. **Please list any other health professionals your child is seeing and their area of expertise. Include any therapies your child is in. (Ex. PT, OT, Speech, Counselor, Naturopath, etc)**

_____

_____

_____

4. Please list any medications/herbs/vitamins/other that your child is taking.

Medication/Supplement	Reason for Taking	Medication/Supplement	Reason for Taking

CURRENT HEALTH CONDITIONS

5. What are the primary health concerns for your child?

_____
_____
_____
_____

6. Please describe when your child's issues first began and how they've progressed since:

_____
_____
_____
_____

7. What makes things better?

_____
_____
_____

8. What makes things worse?

_____
_____
_____

HEALTH GOALS FOR YOUR CHILD

9. What are your top 3 health goals for your child?

1. _____
   _____
2. _____
   _____
3. _____
   _____

10. What would you like to gain from chiropractic care?

☐ Resolve existing condition ☐ Overall wellness & prevention ☐ Both

11. If you've ever visited a chiropractor before, please list their name(s) and specialty:

_____
_____
_____

PREGNANCY AND FERTILITY HISTORY

12. Please explain any fertility challenges you had:

_____
_____
_____
_____
_____
_____

13. If mother smoked, how many per week? _____

14. If mother drank, how many per week? _____

15. If mother exercised, what type and how much per week? _____
_____

16. If mother was ill during the pregnancy, please explain. _____
_____
_____
_____

17. Please explain any ultrasound findings. _____
_____
_____

18. Please explain any notable episodes of emotional and/or physical stress during the pregnancy. _____
_____
_____
_____

19. Please explain any other concerns or notable remarks about your child's conception or pregnancy. _____
_____
_____

LABOR AND DELIVERY HISTORY

20. At how many weeks was your child born? _____

21. Child's birth was:

- ☐ Vaginal birth
- ☐ Scheduled C-Section
- ☐ Emergency C-Section

22. Child's birth was:

- ☐ At home
- ☐ At a hospital
- ☐ At a birthing center
- ☐ Other (please specify) _____

23. Birth Provider's Name _____

24. Please check any applicable interventions or complications:

- ☐ Breech
- ☐ Cord-wrapped
- ☐ None
- ☐ Epidural
- ☐ Episiotomy
- ☐ Forceps
- ☐ Induction
- ☐ Manual assistance
- ☐ Pain meds
- ☐ Vacuum extraction
- ☐ Other (please specify) _____

25. Please describe any other concerns or notable remarks about your child's labor or delivery.

_____

_____

26. Child's birth weight **Child's birth height** **APGAR at birth** **APGAR at 5 min.**

_____ _____ _____ _____

GROWTH AND DEVELOPMENT HISTORY

27. If your child was breastfed, how long? _____

28. If there was difficulty with breastfeeding, was one side more difficult for them? ____

_____

29. If you ever used formula, which one(s)and at what age? _____

_____

30. If your child suffered or is currently suffering from colic, reflux, skin issues, or constipation as an infant, please explain: _____

_____

_____

31. If your child has ever arched their neck/back, felt stiff, or banged their head, please explain:

_____

_____

32. At what age did your child… (Notate any skipped or out of order milestones.)

Skill	Age	Did anything concern you about this skill?
Respond to sound (birth – 1 month)		
Follow an object (1-3 months)		
Hold their head up (2-4 months)		
Vocalize (2-4 months)		
Begin teething (4-7 months)		
Sit alone (6-8months)		
Crawl (6-10 months)		
Walk (9-15 months)		
Begin solid foods		
Begin cow's milk		

33. Please list any food intolerances or allergies and when they began:

Food intolerance / Allergy	When it began

34. Please list any hospitalizations or surgeries and the year:

Hospitalization / Surgery	Year

35. Please list any major injuries, accidents, falls, and/or fractures your child has sustained in their lifetime and the year:

Injury	Year

36. Have you chosen to vaccinate your child?

- ☐ No
- ☐ Yes, on schedule
- ☐ Yes, on a delayed or selective schedule

37. If yes, please list any vaccination reactions:_____

_____

_____

38. Please list antibiotic use for your child:

Antibiotic	Reason	How many times

39. If your child has had difficulty with bonding and social development, please explain:

_____

_____

_____

_____

40. If your child has had night terrors or difficulty sleeping, please explain:_____

_____

_____

_____

41. If your child has had any behavioral, social, or emotional issues, please explain:

_____

_____

_____

42. How many hours per day does your child typically spend watching a TV, computer, tablet, or phone? _____

43. How would you describe your child's diet?

☐ Mostly whole, organic foods ☐ High amount of processed foods ☐ Breastmilk only

44. Are there any other health concerns or is there anything else you'd like for us to know about your child? _____

_____

_____

PATIENT REVIEW OF SYSTEMS

The nervous system controls and coordinates all organs and structures of the human body. Please check the corresponding boxes for each symptom or condition your child has experienced – past and/or present.

	Past	Present
ADHD/ADD		
Allergies and/or Autoimmune Challenges		
Anxiety and Emotional Instability		
Asthma		
Balance and Coordination Challenges		
Behavior Issues		
Bladder and Urination Issues		
Blood Sugar Issues		
Bronchitis and Pneumonia		
Chronic Chest Colds and Cough		
Chronic Inflammation		
Circulation Issues and Cold Feet		
Colic and Excessive Crying		
Constipation		
Depression and/or Lack of Confidence		
Ear and/or Sinus infections		
Gas Pain and Bloating		
Gluten and/or Casein Intolerance		
Handwriting and Fine Motor Skill Challenges		
Headaches or Migraines		
Hormonal Challenges		
Hyperactivity and Impulsivity		
Jaw, Swallowing, Sensory Food Aversions		
Kidney Challenges		
Latching/Nursing Difficulties		
Lightheadedness and Dizziness		
Low Back Pain and Stiffness		
Low Energy/Fatigue		

Low Tone and Coordination Challenges		
Lumbopelvic/SI Joint Pain		
Metabolism and Weight Control Issues		
Motor Milestone Delays		
Nausea and Malaise		
Plagiocephaly		
Projectile Vomiting		
Reflux and Excessive Spit Up		
Sensory Processing Challenges		
Skins Conditions / Rashes		
Sleeping Difficulties		
Social/Emotional Challenges		
Sore Throat / Strep / Upper Respiratory Infections		
Speech and Communication Delays		
Stiffening, Rigidity, Arching / Stiff Neck and Shoulders		
Swollen Tonsils and Adenoids		
Tantrums and Meltdowns		
Tight Hamstrings and Calves		
Toe Walking		
Torticollis		
Ulcerative Colitis / Crohn's / IBS		
Vision and/or Hearing Issues		
Visual and/or Auditory Processing Challenges		
Weak Ankles and Arches		

ACKNOWLEDGEMENT AND CONSENT

Parent/Guardian

_____ _____

Signature Date

Doctor

_____

Signature

Informed Consent for Chiropractic Care

Chiropractic care, like all forms of health care, while offering considerable benefits, may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases, injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include strain/sprain injuries, irritation of a disc condition, and rarely, fractures. One of the rarest complications associated with chiropractic care, occurring at a rate of 1 or 2 instances per one million cervical spine adjustments, may be a vertebral artery injury that could lead to stroke.

Prior to receiving chiropractic care at Harmonized Neurology Family Chiropractic, a health history and physical examination will be completed. These procedures are performed to assess your specific condition, your overall health, and your spine health. These procedures will assist us in determining if chiropractic care is needed or if any further examinations or studies are required. In addition, they will help us determine if there is any reason to modify your care or provide a referral to another health care provider. All relevant findings will be reported to you along with a care plan prior to beginning care.

I understand that alternatives to chiropractic care may include physical therapy, medical care, or other interventions, and I am free to discuss these options before proceeding.

I understand and accept that there are risks associated with chiropractic care and give my consent to the examinations that the doctor deems necessary, and to the chiropractic care, including spinal adjustments, as reported following my assessment.

I understand that I have the right to ask questions and withdraw my consent for care at any time.

For Minors or Dependents
If signing for a minor or dependent, I confirm that I am their legal guardian and authorized to consent to care on their behalf.

Acknowledgment of Understanding
I acknowledge that I have had the opportunity to ask questions about this consent form and that all my questions have been answered to my satisfaction.

Practice Information
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Signatures
Patient Name (Printed): _____
Patient Signature: _____
Date: _____

If signing for a minor or dependent:
Guardian Name (Printed): _____
Guardian Signature: _____
Date: _____

Witness Name (Printed): _____
Witness Signature: _____
Date: _____

MINOR CONSENT FORM

Patient Name (Minor): _____ **Date of Birth**: _____

I, _____, am the parent/legal guardian of the above-named minor. I hereby authorize Harmonized Neurology Family Chiropractic to provide chiropractic care and related services to my child. I understand the nature of the care and any potential risks and benefits have been explained to me.

I further authorize:

- **Sharing of Information:** Authorization to share the minor's health records with other healthcare providers if needed.
- **Appointment Accompaniment:** The people listed, have my permission to accompany the minor to appointments.

Name	Relationship to Minor

I understand that I can revoke this consent in writing at any time.

Parent/Guardian Name (Printed): _____ **Parent/Guardian**

Signature: _____ **Date**: _____

Acknowledgment of Privacy Practices Notice Availability

This is to acknowledge that I have been informed of the availability of the Notice of Privacy Practices from Harmonized Neurology Family Chiropractic. I understand that:

1. I may request a full copy of the Notice of Privacy Practices at any time.
2. The Notice of Privacy Practices explains how my health information may be used and disclosed and outlines my rights regarding this information.
3. A summary of the Notice of Privacy Practices is also available for my convenience.

I further understand that I am entitled to ask any questions about the Notice of Privacy Practices or seek clarification if needed.

Patient Name (Printed): _____
Patient Signature: _____
Date: _____

If you have any questions or require a copy of the Notice of Privacy Practices, please let us know. We are here to assist you.

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Financial Policy Agreement

Welcome to Harmonized Neurology Family Chiropractic! We are committed to providing you with the highest quality neurologically-focused chiropractic care. To ensure clear communication and understanding regarding our financial policies, we ask that you carefully read and sign this agreement before beginning treatment.

Payment for Services:

- **Payment Due at Time of Service:** Payment for services is due at the time the services are rendered, unless prior arrangements have been made in writing with our office.
- **Accepted Forms of Payment:** We accept the following forms of payment. Please note the cash versus card price adjustment.
    - Cash
    - Check (made payable to Harmonized Neurology Family Chiropractic
    - Visa, Mastercard, American Express, Discover
    - HSA/FSA cards
- **Returned Checks:** Returned Checks: If a check is returned by your bank for any reason (e.g., insufficient funds, closed account), you will be responsible for the following:
    - The original amount of the check.
    - Any fees charged to Harmonized Neurology by our bank for the returned check.
    - We recognize that mistakes happen and therefore, do not charge processing fees.

Insurance:

- **Non-Participating Provider:** Harmonized Neurology Family Chiropractic is a non-participating provider with all insurance plans, including Medicare and Medicaid. This means that we do not bill insurance companies directly.
- **Patient Responsibility:** You are responsible for the full payment of all services rendered at the time of service.
- **Superbill/Receipt:** Upon request, we will provide you with a receipt (superbill) for you to submit to your insurance company for potential out-of-network reimbursement. We make no guarantees regarding reimbursement from your insurance company.

Care Plans:

- We offer highly competitive and largely discounted Care Plans. Care plans are offered for both Restoration Care and Wellness Care. A signed Care Plan Agreement is required.

Missed Appointments/Cancellations:

- **Life is busy and we completely understand that unexpected things can happen and simply encourage you to share any scheduling conflicts with us as soon as possible.**
- **We request a 24-hour cancellation notice.**

Fees for Reports and Records:

- A fee may be charged for providing copies of medical records, reports, or other documentation. Please inquire about our current fee schedule.

Changes to Financial Policy:

- We reserve the right to modify this financial policy at any time. You will be notified of any significant changes.

Agreement:

I have read, understand, and agree to the financial policies outlined in this document. I understand that I am financially responsible for all services rendered at Harmonized Neurology Family Chiropractic.

Patient Signature _____

Printed Patient Name_____

Date _____

CONSENT TO COMMUNICATE

Patient Name: _____

I authorize Harmonized Neurology Family Chiropractic to contact me using the following methods (please check all that apply):

- ☐ **Phone call**
- ☐ **Email**
- ☐ **Text Message**

I understand that:

1. These methods of communication may not be secure, and there is a risk of unauthorized access.
2. The purpose of this communication may include appointment reminders, follow-ups, or practice updates.

I consent to receive communications from Harmonized Neurology Family Chiropractic and understand that I can revoke this consent in writing at any time.

Signature: _____ **Date**: _____

Minor Photo Release Form

I, the undersigned, being the parent or legal guardian of the minor named below, hereby grant Harmonized Neurology Family Chiropractic permission to use the minor's likeness in a photograph, video, or other digital media in any and all of its publications, including web-based publications, without payment or other consideration.

I understand and agree that all photos will become the property of Harmonized Neurology Family Chiropractic and will not be returned. I hereby irrevocably authorize Harmonized Neurology Family Chiropractic to edit, alter, copy, exhibit, publish, or distribute these photos for any lawful purpose. In addition, I waive any right to inspect or approve the finished product wherein the minor's likeness appears. Additionally, I waive any right to royalties or other compensation arising or related to the use of the photos.

I hereby hold harmless, release, and forever discharge Harmonized Neurology Family Chiropractic from all claims, demands, and causes of action which I, the minor, my heirs, representatives, executors, administrators, or any other persons acting on my or the minor's behalf or on behalf of the minor's estate have or may have by reason of this authorization.

Minor's Name: _____

Parent/Guardian Printed Name: _____

Parent/Guardian Signature: _____

Date: _____

Adult Photo Release Form

I, the undersigned, hereby grant Harmonized Neurology Family Chiropractic permission to use my likeness in a photograph, video, or other digital media in any and all of its publications, including web-based publications, without payment or other consideration.

I understand and agree that all photos will become the property of Harmonized Neurology Family Chiropractic and will not be returned. I hereby irrevocably authorize Harmonized Neurology Family Chiropractic to edit, alter, copy, exhibit, publish, or distribute these photos for any lawful purpose. In addition, I waive any right to inspect or approve the finished product wherein my likeness appears. Additionally, I waive any right to royalties or other compensation arising or related to the use of the photos.

I hereby hold harmless, release, and forever discharge Harmonized Neurology Family Chiropractic from all claims, demands, and causes of action which I, my heirs, representatives, executors, administrators, or any other persons acting on my behalf or on behalf of my estate have or may have by reason of this authorization.

Printed Name: _____

Signature: _____

Date: _____