BROUSE CHIROPRACTIC & NUTRITION

PEDIATRIC PATIENT QUESTIONNAIRE

Date: _____

Child's Name: _____ Age: _____Grade: _____ Gender: M F

Home Address: _____ Date of Birth: _____ / _____ / _____

City, State, Zip: _____ Home Phone: ( ) _____

Parent/Guardian Name: Mother_____ Father_____ Marital Status: S M D W

Home Phone: _____ Cell Phone:_____ Work Phone:_____

Email Address: _____

How were you referred to this office? _____

Have you or your child ever had chiropractic care before? Yes No If Yes, Dr.'s Name:_____

Is this appointment related to an auto accident? ❑ Yes ❑ No IF Yes, please fill out the Auto Accident Questionnaire.

Please list any drugs or medications your child is taking? _____

_____

Please list any vitamins/ herbs/ homeopathics/ other your child is taking?_____

_____

Please list any allergies your child has:_____

Current Health

Reason for this visit -**What brings your child to our office?** _____

_____

What are your Health Objectives for your child? What are your goals and what you would like to see us help you with?

_____

1. When did this condition begin? _____
2. Is this condition ❑ Getting Worse ❑ Improving ❑ Intermittent ❑ Constant ❑ Not Sure
3. What makes the problem better?_____
4. What makes the problem worse?_____
5. Has your child been treated for this problem? ❑ Yes ❑ No , If Yes, please explain_____

   _____
6. Does your child eat well? ❑ Yes ❑ No Does your child have regular bowel/bladder movements? ❑ Yes ❑ No
7. Has your child ever been checked for vertebral subluxations? ❑ Yes ❑ No ❑ Don't Know
8. Have you ever been told that your child has a spinal curvature, spinal arthritis, or inherited spinal problem?

   Yes / No _____
9. How would you rate your child's posture? Poor - 1 2 3 4 5 6 7 8 9 10 - Excellent
10. Does your child suffer from any of the following:

- ❑ Acid Reflux
- ❑ Allergies
- ❑ Asperger's
- ❑ Asthma/Wheezing
- ❑ ADD / ADHD
- ❑ Anxiety
- ❑ Autism
- ❑ Back Pain
- ❑ Bed Wetting
- ❑ Behavioral issues
- ❑ Cancer
- ❑ Chronic Lung Infection
- ❑ Colic
- ❑ Constipation
- ❑ Croup
- ❑ Depression
- ❑ Difficulty Concentrating
- ❑ Digestive Disorders
- ❑ Ear Infections
- ❑ Eczema
- ❑ Headaches
- ❑ High Blood Pressure
- ❑ Lazy/Cross Eye
- ❑ Leg Pain/Cramps
- ❑ Neck Pain/shoulder pain
- ❑ OCD
- ❑ Recurrent Colds/Flu
- ❑ Seizures
- ❑ Sensory ProcessingDisorder
- ❑ Sinus Problems
- ❑ Sleep Issues
- ❑ Trouble Sleeping
- ❑ Visual Problems
- ❑ Weight Gain/problems
- ❑ Other:_____

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

_____

8. How many times has your child been prescribed antibiotics in the past 6 months? _____ Total during lifetime? _____
9. Has your child received vaccinations? Y / N Any concerns with vaccinations? Y / N

_____

10. Has your child ever been involved in an auto accident or suffered any other traumatic injury? {falls, sport injuries}

_____

11. Has your child been hospitalized or have any surgical history? (Please list below all surgeries and hospitalizations and year)

_____

_____

12. Sport Activities ___Soccer ___Running ___Dance ___Football ___Swimming ___Martial Arts ___Gymnastics ___Horseback Riding ___Baseball/softball ___Tennis ___None Other _____
13. Computer / Video / TV use: ____less than 30 min a day ____less than 60 min a day ____more than 60 min a day

Prenatal History

1._____Hospital birth or _____Home birth
2._____Obstetrician or _____Midwife
3. Birth Intervention? _____Forceps _____Vacuum _____C-Section _____Pulled by hands _____Natural
4. Any complications during pregnancy?_____
5. Any illness of mother during pregnancy? _____
6. How many ultrasounds during pregnancy? _____
7. Please list any medications/drugs taken during Pregnancy?_____
8. List any Vitamins/Supplements taken during Pregnancy?_____
9. Cigarettes or Alcohol during Pregnancy?_____
10. Complications during delivery?_____
11. How long was your child's hospital stay? _____
12. Any Genetic disorders or disabilities?_____
13. Birth weight: _____ Birth length _____ APGAR _____

Development History: (if you remember): At what age did the child-

Respond to sound _____ Follow an object _____ Hold head up _____ Vocalize_____
Sit alone _____ Teethe _____ Crawl _____ Stand _____ Walk _____

Feeding History:

Is/was your child breast fed Yes No If yes, how long?_____
Any difficulty with breastfeeding? ❑ Yes ❑ No If Yes, please explain _____

_____

Any difficulty with bonding? ❑ Yes ❑ No If Yes, please explain _____

_____

Any behavioral problems? ❑ Yes ❑ No If Yes, please explain _____

_____

Any night terrors, sleepwalking or difficulty sleeping? ❑ Yes ❑ No If Yes, please explain_____

_____

Formula introduced at age? _____ What type?_____
Age child started daycare _____

Does your child seem normal for their age? ❑ Yes ❑ No If No, please explain _____

_____

Introduced cow's milk at?_____Months Began solid foods at? _____ Months

Please list any foods/juice intolerance _____

_____

Allergies:___Eggs ___Soy ___Fish and Shellfish ___Sugar ___Milk or Lactose ___Sulfites ___Nut ___Wheat/Gluten

Please list any allergies, your child has not listed ABOVE:_____

Any pets at home Yes No , If Yes, what_____ Any smokers at home? Yes No

Family History: List name and ages of other children

1. _____ age: _____ Health concerns or complaints: Y / N _____
2. _____ age: _____ Health concerns or complaints: Y / N _____
3. _____ age: _____ Health concerns or complaints: Y / N _____
4. _____ age: _____ Health concerns or complaints: Y / N _____
5. _____ age: _____ Health concerns or complaints: Y / N _____
6. _____ age: _____ Health concerns or complaints: Y / N _____

Do you know what a subluxation is? ❑ Yes ❑ No

Do any of your friends or relatives see a chiropractor? ❑ Yes ❑ No

If yes, do they use chiropractic for Health maintenance/optimization Health Problems Both

Are you seeking chiropractic for Health maintenance/optimization Health Problems Both

What would you like to gain from chiropractic care or what are your goals?_____

_____

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

_____

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

Parent/Guardian Signature: _____ Date: _____

CONSENT TO TREATMENT OF A MINOR

I, the undersigned, parent/person having legal custody/legal guardianship of _____ a minor, do hereby authorize,Wellness 1st, P.C. DBA: Brouse Chiropractic & Nutrition, to perform any x-rays, examination and chiropractic diagnosis or treatment, which is deemed advisable by a licensed chiropractor, be rendered under the general or special supervision of any licensed chiropractor.

It is understood that this authorization is given in advance of any specific diagnosis or treatment being required but is given to provide authority to the above chiropractor, meeting the requirements of this authorization may, in the exercise of his/her best judgment, deem advisable.

This authorization shall remain effective unless revoked in writing and delivered to the Wellness 1st, P.C., DBA: Brouse Chiropractic & Nutrition.

Printed Name of parent or legal guardian:_____

Signature:_____ Date:_____

INSURANCE/HIPAA INFORMATION

DO YOU HAVE HEALTH INSURANCE? ☐ Yes ☐ No
*PLEASE PRESENT INSURANCE CARDS FOR VERIFICATION

Assignment and Release

I certify that I, and/or my dependent(s), have insurance coverage with insurances that I presented to Wellness 1st, P.C. and assign directly to Wellness 1st, P.C. and Dr. John Brouse all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above name doctor may use my health care information and may disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Initial_____

Notice of Privacy Practices

I have received a copy of the HIPAA Privacy Regulations and understand that my private healthcare information is protected.

Initial_____

Informed Consent

I have received a copy of the informed consent to have chiropractic treatment administered and give Wellness 1st, P.C. (DBA: Brouse Chiropractic& Nutrition) consent to treat utilizing chiropractic care.

Initial_____

I have initialed all three areas above and understand all three areas.

Signature of patient/parent _____

Date_____Relationship to patient_____