Billing
CHIROPRACTIC
HEALTH + WELLNESS

Pediatric Patient Questionnaire

Confidential Patient Information

Child's Name:		Parent/Guardian Names:	
Address:		City, State, Zip:	
Email:	Cell Phone:	Home Phone:	Age:
Child's SS #:	Birthdate:	Height:	Weight: ___________ Birthweight: ___________

How did you hear about us?

Who is your primary care physician?

Is your child receiving care from any other health professionals? ___Yes ___No
If yes, please name them and their 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(s) first begin?	How did the problem start? ___Suddenly ___Gradually ___Post-Injury

Has your child ever received care for this problem before? ___Yes ___No
If yes, please 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 health goals for your child?	**What would you like to gain from chiropractic care?**
1.	___ Resolve existing condition
2.	___ Overall wellness
3.	___ Both

Have you ever visited a chiropractor? ___Yes ___No If yes, what is their name: ____

Pregnancy & Fertility History

Please tell us about your pregnancy: ___Vaginal ___Forceps ___Home ___Hospital ___Breech ___C-Section

Any fertility issues?	___Yes ___No	If yes, please explain:
Did mother smoke?	___Yes ___No	If yes, how many per week:
Did mother drink?	___Yes ___No	If yes, how many per week:
Did mother exercise?	___Yes ___No	If yes, please explain:
Was mother ill?	___Yes ___No	If yes, please explain:
Any ultrasounds?	___Yes ___No	If yes, please explain:

Please explain any notable episodes of mental or physical stress during your pregnancy:

Please explain any other concerns or notable remarks about your child's conception or pregnancy:

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Pediatric Chiropractic Health Questionnaire

APGAR Scores: ______________ ______________ Present at Birth? ___Jaundice (yellow) ___Cyanosis (blue)

Congenital Anomalies/Defects:

Infant Feeding: ___Breasts ___Bottle ___Formula

Quality of Sleep: ___Good ___Fair ___Poor

Immunization History:

Any childhood diseases:

Purpose of last visit to MD: Date:

Purpose of this appointment:

Developmental History: At what age did the child...

Smile:	Stand:	Walk alone:	Crawl:
Holds head up:	Sit alone:	Talk:	
Follows objects with his/her eyes:		Holds object with hands:	

Has this child ever suffered from: (circle all that apply)

Dizziness	Behavioral problems	Arm problems	Growing pains
Diabetes	Backaches	Ruptures/hernias	Stomachaches
Anemia	Headaches	Blood disorders	Chronic earaches
Poor appetite	Digestive disorders	Heart troubles	Cold/Flu
Bed Wetting	Rheumatic fever	Diabetes/hypoglycemia	Allergies
Fainting	Hyperactivity	Paralysis	Constipation
Neck problems	Seizures	Broken bones	Diarrhea
Joint problems	Walking problems	Leg problems	Asthma

* Any other:

Surgery:

Medications:

Accidents:

Family History:

Has your child ever been treated on an emergency basis: ___Yes ___No If so, why?

I agree to assume responsibility for any charges created by the chiropractic care and give consent for my child to be examined and/or treated by Dr. Billing and his staff

Parental Signature: Date:

Patient Name: ______________________________ **Date:** _________________________

Terms of Acceptance

The goal of our office is to enable patients to gain control of their health. To attain this, we believe communication is the key. There are often topics that are hard to understand and we hope this document will clarify those issues for you.

Please read the below and if you have any questions please feel free to ask one of our staff members.

Informed Consent:

A patient, in coming to the chiropractic doctor, gives the doctor permission and authority to care for the patient in accordance with chiropractic tests, diagnosis, and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or care if he/she is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known, or to learn through healthcare procedures what he/she is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the chiropractic physician. The chiropractic doctor provides a specialized, non-duplicating health care service. Your doctor or chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regimen. I understand that if I am accepted as a patient by a physician at Billing Chiropractic, I am authorizing them to proceed with any treatment that they deem necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

Missed Appointments:

There is a possible fee charged for all appointments that are not canceled prior to scheduled visit.

Consent to Evaluate and Treat a Minor:

I, _________________________ being the parent or legal guardian of _________________________, have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Communication:

In the event that we would need to communicate your healthcare information, to whom may we do so?

Spouse: ______________________________________

Children: ____________________________________

Others: ______________________________________

No one: _______

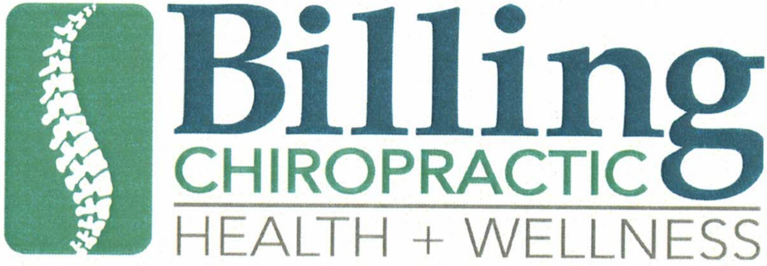
May we leave messages regarding your personal healthcare information on the answering device, i.e. home answering machines or voicemails? Yes [ ] No [ ]

Acknowledgement

I have read and fully understand the above statements. I have reviewed the notice of privacy practices (HIPAA) and have been provided an opportunity to discuss my right to privacy. Upon request I will be given a copy.

Print Name: ____

Signature: ______________________________________ Date: ______________________



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Consent to Treat a Minor Child

Date: ____________________________

I hereby authorize named doctor, and whomever he or she may designate as assistants, to administer the required care as deemed necessary to my child, (name of child) ____________ ____.

Parent/Guardian Signature: ____

Witnessed: ____