PEDIATRIC PATIENT QUESTIONNAIRE

PATIENT INFORMATION:

Child's Name________________________ Parent(s)/Guardian(s) Name ______________________________

Address ___________________________City_________________________ State_______ Zip_______

Home Phone __________________Work Phone___________________ Cell Phone ____________________

Is it okay to contact you at work? ❑Yes ❑No

E-mail________________________ Birthdate __________Age_________

Have you or your child ever had chiropractic care before? You: ❑Yes ❑No Your child: ❑Yes ❑No

If yes, please tell us the doctor's name ____

Were you pleased with your care? ❑Yes ❑No

How did you find out about our office? ____

Is this appointment related to an auto accident? ❑Yes ❑No

If this injury is related to an auto accident, please fill out the Auto Accident Questionnaire.

Is your child receiving care from other health care professionals? ❑Yes ❑No

If yes, please name them and their specialty ____

Who is your family's primary care physician? ____

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:

What health condition brings your child to our office? _____________________________________

____

When did the symptoms first begin? ____

How did the problem start? ❑Suddenly ❑Gradually ❑Post-Injury

Is this condition: ❑Getting worse ❑Improving ❑Intermittent ❑Constant ❑Not Sure

What makes the problem better? ____

What makes the problem worse? ____

Has your child ever had a similar condition? ❑Yes ❑No

Please explain ____

Has your child been treated for this problem before? ❑Yes ❑No

Please explain____

Patient Name:______________________________ Date:____________

Does your child eat well? ❑Yes ❑No

What does your child commonly eat for breakfast:______________________________

Lunch:______________________________

Dinner:______________________________

Snacks:______________________________

Does your child have regular bowel/bladder movements? ❑Yes ❑No

Has your child ever been checked for vertebral subluxations? ❑Yes ❑No ❑Don't Know

PAIN CHART:

Use the appropriate symbols. Mark areas of radiation. Include all affected areas.

Numbness	Pins & Needles	Burning	Aching	Stabbing
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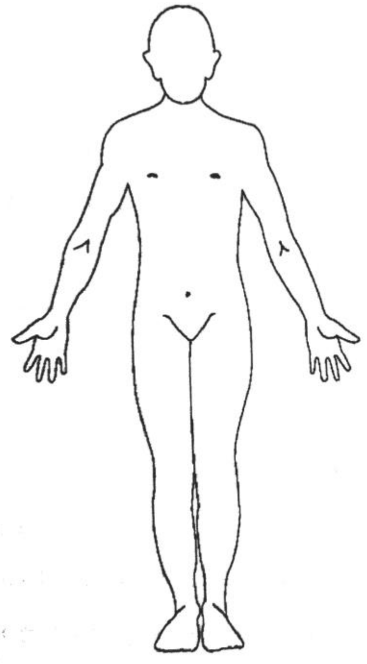
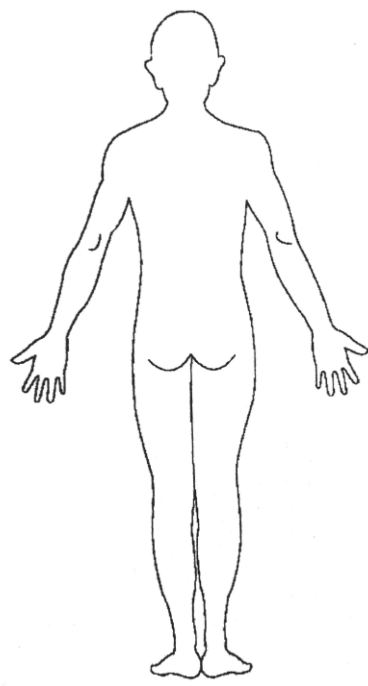
Please mark on the pain scale from 1-10 the pain you feel with this condition, 10 being the worst pain you have felt with this condition.





Patient Name:____ Date:________________

HEALTH HISTORY:

Child's birth was ❑At Home ❑At A Birthing Center ❑At A Hospital

My obstetrician/midwife/family physician was ______________________________________

Child's birth was

- ❑ Natural vaginal (no medications/interventions)
- ❑ Vaginal with interventions
- ❑ Induction ❑Pain Medication ❑Epidural ❑Episiotomy ❑Vacuum Extraction ❑Forceps
- ❑ Other
- ❑ C-section
- ❑ Scheduled ❑Emergency

Please list reasons for any interventions/complications __________________________________

____

Child's birth weight _______ Child's birth height _______ Current weight _____ Current height ________

APGAR score at birth_______ APGAR score after 5 minutes_______ Not sure/can't recall ❑

Was the child vaccinated or receive inoculations before leaving the hospital at birth? ❑Yes ❑No

GROWTH & DEVELOPMENT:

Was your child alert and responsive within 12 hours of delivery? ❑Yes ❑No

If no, please explain ____

At what age did the child:

Respond to sound_____ Follow an object_____ Hold head up_____Vocalize ______

Sit alone_____ Teethe______ Crawl______ Walk______

Patient/Hospitalization/Surgical history (please list below all surgeries and hospitalizations, including the year):

____

____

Please list any major injuries, accidents, falls and/or fractures your child has sustained in his/her lifetime, including the year:

____

____

Is/was your child breastfed? ❑Yes ❑No If yes, how long? ______

Formula introduced at age________ What type? ____________________________________

Introduction of cow's milk at age_____ Began solid foods at age _____

Please list any foods/juice intolerance ____

Did mother smoke during pregnancy? ❑Yes ❑No Did mother drink alcohol during pregnancy? ❑Yes ❑No

Did mother drink (or eat) diet sodas or artificial sweeteners during pregnancy? ❑Yes ❑No

Any illness of mother during pregnancy? ❑Yes ❑No

If yes, please explain including treatment/medications/supplements_____________________________

____

List any drugs/medications (including over the counter) taken during pregnancy_____________________

____

List any supplements taken during pregnancy ____

____

Any exposures to ultrasound? ❑Yes ❑No If so, how many and what was the medical reason? __________

____

Any pets at home? ❑Yes ❑No Any smokers at home? ❑Yes ❑No

Has child received any vaccinations? ❑Yes ❑No If yes, which ones, at what age, and list any reactions_______

____

Patient Name:____ Date:____________________

Has child received any antibiotics? ❑Yes ❑No If yes, how many times and list reason ____________________
____
Any difficulty 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 __________________
____
Age child began daycare ____________ Average number of hours of TV/Digital media (iPod, iTouch, iPad, video games, etc.) per week ____
Was there any point at which you said, "that doesn't seem normal/right" since your child was born? ❑Yes ❑No
If yes, please explain ____
Does your child seem normal for his/her age? ❑Yes ❑No If yes, please explain ______________________
____

FAMILY HISTORY REVIEW

Check those involving immediate family and add identification: M=Mother; F=Father; S=Siblings; G=Grandparents

❑Cancer, type ❑M ❑ F ❑ S ❑ G ❑	❑Depression ❑M ❑ F ❑ S ❑ G ❑	❑Diabetes ❑M ❑ F ❑ S ❑ G ❑	❑Back Problems ❑M ❑ F ❑ S ❑ G ❑
❑Heart Disease ❑M ❑ F ❑ S ❑ G ❑	❑Liver Disease ❑M ❑ F ❑ S ❑ G ❑	❑High Blood Pressure ❑M ❑ F ❑ S ❑ G ❑	❑High Cholesterol ❑M ❑ F ❑ S ❑ G ❑
❑Lung Problems ❑M ❑ F ❑ S ❑ G ❑	❑Scoliosis ❑M ❑ F ❑ S ❑ G ❑	❑Neck Problems ❑M ❑ F ❑ S ❑ G ❑	❑Osteoporosis ❑M ❑ F ❑ S ❑ G ❑
❑ Seizures ❑M ❑ F ❑ S ❑ G ❑	❑Osteoarthritis ❑M ❑ F ❑ S ❑ G ❑	❑Rheumatoid Arthritis ❑M ❑ F ❑ S ❑ G ❑	

❑ Other ____
____

DO YOU KNOW ABOUT CHIROPRACTIC?

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

Patient Name:____ Date:____________________

OUR OFFICE POLICIES

Payment Policy

Our office is not affiliated with HMO's, PPO's, or Health/Medical insurance companies. Patients who carry any form of medical or health insurance should know that ALL services rendered by this office are charged directly to the patient. Payment in full is due and payable at time of service. This office does not carry balances. If payment is not received, the office uses outside sources to collect balances due.

Initials _______________

Health Medical Insurance

If you have insurance that offers chiropractic benefits or other benefits in our office, and you intend to submit bills, please let us know. As a courtesy we will electronically submit your bill to your medical insurance company for services rendered. Depending on which medical insurance plan you chose you may or may not have coverage for an out of network provider. If coverage is denied by your medical insurance plan, Applied Health – P.A.K. will not normally resubmit the forms or supply supporting documentation to the medical insurance for possible reimbursement. However, a charge of $25 will be applied for statements that need to be resubmitted by your request of the request of your medical insurance company.

Should your reimbursement check be mistakenly issued to Applied Health – P.A.K. from your medical insurance company, the check will be voided and sent to you (the patient). It will be your responsibility to contact your insurance company for reissuance.

Initials _______________

Nutritional Supplements/Health Supplies

Nutritional supplements and other health supplies must be paid for at time of service.

Initials _______________

Returned Checks

There will be a $35.00 charge on all returned checks. If multiple checks are returned during the course of your care, check privileges will be revoked. Future payment of your account will only be accepted in cash, credit card, or care credit.

Initials _______________

Missed Appointments

Should the need arise to reschedule your appointment please give the office a minimum of 24 hours notice otherwise you will be charged $25.

Late Arrivals - Due to the high demand of our services at Applied Health – P.A.K. it is imperative that you arrive on time for your appointment. Patients who arrive 10 minutes after their scheduled appointment time will need to reschedule and will be charged for 50% of their full appointment fee.

Missed Appointments – Appointments that are completely missed will be charged for a full appointment. The staff is unable to fill your time slot without an appropriate notice in advance. By missing your appointment you take away the opportunity for someone on our waiting list to become well through care at Applied Health – P.A.K.

Initials _______________

Any questions you have regarding our policies are welcome at any time.

Patient Name:____ Date:________________

I hereby authorize the doctor to provide me with a consultation and examination in order to determine if my case can be helped by chiropractic and the care provided here at Applied Health P. A. K. I also understand that other exams and tests such as X-rays, lab tests, etc. may be necessary to gain more information regarding my health. I understand that if I am accepted as a patient here at Applied Health P. A. K., the doctor will discuss with me which course of care would be best for my case.

Patient Signature	Patient Name
Parent/Guardian	Signature Date
Witness	Date

Patient Name:____ Date:____________________

CONFIDENTIALITY AGREEMENT

To Our Valued Patients:

We at Applied Health P. A. K. have always made your privacy one of our top priorities. We would like to inform you of the measures our office has taken to ensure your rights of patient privacy (in accordance with HIPAA).

The following have been incorporated to secure your private patient information:

1. We do not obtain your social security number for the purpose of patient identification. By removing this part of your private information it becomes much less likely that in the unlikely event of a security breach your personal or professional finances will not be at risk. You are automatically assigned a randomized patient number when your patient chart is created.
2. All of your information is kept on cloud based medical software specifically designed to be in compliance with the Health Insurance Portability and Accountability Act (HIPAA).
3. All employees and contractors at Applied Health –P.A.K. undergo training regarding HIPAA prior to having access to private information. Once the training is complete, employees and contractors sign a strict confidentiality agreement that requires all patient information, including but limited verbal, written or other information, within the confines of our secure software at all times.
4. All computers with patient data are password secure and require multiple logins prior to accessing patient data. Access to the computers is restricted and each employee has a unique, identifiable user identification that is logged during use of patient information.
5. Only one person may access a patient account at any given time. The software restricts multiple users from accessing the same patient information at the same time.
6. Patients are not allowed behind the desk at any time. At no time are unauthorized, non-employees allowed into the front desk area. Please ask for help with product that you may be interested in.
7. Once you arrive in the clinic you are securely checked into our secure, HIPAA compliant, software and at this time there is no need to write your name on a sign in sheet for regular appointments.

We communicate with our patients through mail, e-mail, and by phone. Below is a list of how we correspond with you. Please indicate any items that you do NOT wish to receive:

Mailers: ❑Birthday greetings ❑Holiday cards ❑Health newsletters ❑US Post Mailings ❑Healthcare maintenance reminders ❑Thank you cards for your referrals ❑Electronic

Phone Calls: ❑Missed appointment rescheduling ❑Healthcare maintenance reminders

In Office (Board): ❑"Thank you for referring" board

In the event that we are unable to speak with you directly, please indicate ALL the ways that are acceptable for us to leave a courtesy message for you:

❑ On your home/cell phone answering machine or with your family
❑ Office voicemail or with the receptionist.

We will do our best to honor your requests when communicating with you.

Yours in Health,

The doctors and staff at Applied Health P. A. K.

______________________	____________	______________________	____________
Patient Signature	Date	Witness	Date