Child Chiropractic Health Questionnaire

Name: ____ Birth Date: _______________ Age: _______
Gender: ___________________________Weight:__________________________
Address: ____ City: _______________ Zip Code: ______________
Home Phone: _____________________ Cell Phone: ______________________

1. Most of our patients are referred to our office by a caring family member or friend. What made you decide to visit our office today? Friend/Family member/website Name:__________________________________
   a. We like to thank the people who referred you into our office is it alright for us to send them a thank you for your referral? Y N

PARENT INFORMATION

Parent/Legal Guardian name: ____
Address: ______________________________City:_________________________ Zip Code:___________________
Home Phone: __________________Cell Phone: ___________________Email Address:____________________
Employer:__________________________Address:____
Work Phone:________________________ Position/Title:____

REASON FOR SEEKING CHIROPRACTOR CARE

What concerns do you feel Chiropractic can address for your child?
____

Are these concerns affecting their quality of life? (Please circle only those applicable to you)

Work:	Y	N	Driving:	Y	N	Sleep:	Y	N
School:	Y	N	Walking	Y	N	Sitting:	Y	N
Exercise/Sports:	Y	N	Eating:	Y	N	Other: __________________________		

HEALTH CARE PRACTITIONER HISTORY

Has your child received Chiropractic care? Y N Name of D.C. ___________________________________
How long under care? ☐ ____days ☐ ____Weeks ☐ ____Months ☐ ____Years
Date of last visit: ______________ Why did you stop care? ____
____
How was your experience? ____

Have you consulted or do you regularly consult any of the following providers? (Check all that apply)

☐ Medical Physician ☐ Naturopath ☐ Acupuncture ☐ Homeopath
☐ Massage Therapist ☐ Psychotherapist ☐ Energy Healer ☐ Dentist

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PRENATAL HISTORY

During pregnancy did you use:

☐Drugs/Medication ☐Tobacco/Alcohol

If yes, please explain:____

Location of birth:

☐Home ☐Birthing center ☐Hospital

Describe your Delivery:

☐ Labor was chemically induced ☐ Labor was Doctor Assisted

☐ C-Section Delivery ☐ Forceps/Vacuum Extraction

☐ Doctor Pulled or twisted baby ☐ Premature Delivery

Please Explain:____

How long was labor from regular contractions to birth?:____

How long was the 2nd stage (the pushing phase) of labor?:____

Describe any complications experienced during labor?:____

Did you experience any illness(s) while pregnant ? Y N

If yes, please explain:____

Please explain any genetic or disabilities:____

Birth Weight:__________________________ Birth Length:________________________

APGAR Scores: At 1 min_____/10 At 5 min_____/10

Ultrasounds during pregnancy: Y N Number: ________________

Did you breastfeed this child? Y N If yes, How long:__________________

Did you formula feed this child? Y N if yes, How long:__________________

At what age did you introduce: Solids:_____________ Cow's Milk:________________

Does your child have any **allergies** to any foods? Y N

If yes, please list:____

HEALTH, WELLNESS AND CHIROPRACTIC CARE

The primary system in the body, which coordinates health, is the **CENTRAL NERVOUS SYSTEM**.
The vertebrae, the bones of the spinal column, surround and protect the delicate **NERVE SYSTEM**.
Chiropractors are specialists trained in "early detection" of injury to the **SPINE AND NERVE SYSTEM**.

The information below will help us to see the types of PHYSICAL, EMOTIONAL, AND CHEMICAL stressors your child has been subjected to and **how they may relate to their present spinal, nerve and overall health.**

PHYSICAL STRESS: BIRTH THROUGH CHILDHOOD

The minor, and often ignored, repetitive physical traumas that we have endured are often too numerous to list. Please list the major traumas that your child has experienced.

Has your child had any **accidents or injuries** related to any of the following? (check all that apply)

❑ Automobile ❑ Drops/Falls ❑ Bicycle ❑ Sports ❑ Playground ❑ Abuse

If yes, state **type of injury and date:**

____

____

Has your child ever **hurt/injured** your spine, head, neck, ribs, and chest, upper or lower back, pelvis, or hips? Y N

If yes, state **type of injury and date:**

____

____

Has your child ever **hurt, broken, fractured or sprained** any bones or joints? Y N

If yes, state **type of injury and date:**

____

____

Has your child ever been hospitalized or had surgery? Y N

If yes, **state reason and dates:** ____

____

EMOTIONAL STRESS

It is difficult to separate the emotional stress in our life from the physical response that often occurs. Please indicate if your child has experienced any of the emotional stressors below:

Trauma	Y	N	Loss of loved one	Y	N	Abuse	Y	N
Work or School	Y	N	Parents' divorce	Y	N	Illness	Y	N
Lifestyle change	Y	N						

CHEMICAL STRESS

Have you chosen to vaccination your child: Y N

If yes, check all that your child has received:

❑ DPT ❑ MMR ❑ Chicken Pox ❑ Hepatitis ❑ Other

Describe any and all reactions to vaccine(s): ____________________________________

List Prescription medication and number of doses child has taken:___________________

Has your child ever taken antibiotics? Y N

If yes, please explain:____

Does your child take any vitamins or nutritional supplements? Y N

If yes, what are they and how often are they taken:______________________________

____

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OTHER CONCERNS

Does your child have difficulty interacting with others? Y N

If yes, please explain:____

Have you or anyone else noticed that your child is nervous, twitches, shakes or exhibits rocking behaviors? Y N

If yes, please explain:____

What changes (if any) in your child's health or behavior would you like to see?:____________________________

____

____

CHILD'S HEALTH HISTORY

Please check all of the conditions or diseases that your child has now or has experienced in the past. While these conditions may seem unrelated to the purpose of the appointment, they can affect the overall diagnosis, care plan and the possibility of being accepted for care.

- ❑ Acid Reflux
- ❑ Constipation
- ❑ Frequent colds, coughs
- ❑ Asthma
- ❑ Diarrhea
- ❑ Hyperactivity
- ❑ Learning disorders
- ❑ Bed Wetting
- ❑ Colic
- ❑ Ear infections
- ❑ Sleeping difficulties

INFORMED CONSENT FOR CHIROPRACTIC TREATMENT

I understand that, as in the practice of medicine, in the practice of chiropractic care there are some risks to treatment, including and not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to anticipate and explain all risks and complications. I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based on the facts then known, and is in my best interest.
By signing below I agree to the above and allow the doctor, affiliated with Dawson Chiropractic, to perform such. This consent will cover the entire course of my treatment.
Patient Name: ____ Date: ______________

Patient or Guardian Signature: ____ Date: ______________

AUTHORIZATION FOR CARE OF A MINOR

It is understood and agreed that the payments to the doctor for x-rays is for examination of x-rays only. The x-ray films will remain the property of this office. They are kept on file where they may be seen at any time while I am a patient in this office. I understand that all services are to be paid in full at the time of service, unless other arrangements have been made and agreed in writing.
I hereby authorize the doctors in this chiropractic office and whomever they may designate as their assistant to administer chiropractic care, to work with my condition through the use of adjustments and procedures the doctor deems appropriate. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I agree that I am responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand if I suspend or terminate my care for any reason, any fees for professional services rendered me will become immediately due and payable. I hereby authorize assignment of my insurance rights and benefits (if applicable) directly to the provider for services rendered.
I authorize the use of this signature to allow the insurance companies to pay Dawson Chiropractic directly any amounts payable as my assignment of benefits. I authorize the use of this signature on any insurance submissions.

Patient or Guardian Signature: ____ Date: ______________

NOTICE OF PRIVACY POLICY

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment or practice operations will be made only after obtaining your consent.

· You may request restrictions on your disclosures.
· You may inspect and receive copies of your records within 30 days with a request.
· You may request to view changes to your records.
· In the future, we may contact you for appointment reminders, announcements and to inform you about our practice and its staff.

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

· Conduct, plan and direct my treatment and follow up with multiple healthcare providers who may be involved in that treatment directly or indirectly.
· Obtain payment from third party payers.
· Conduct normal healthcare operations such as quality assessments and physician's certifications.

I have read and understand your Notice of Privacy Practices. A more complete description can be requested. I also understand that I can request, in writing, that you restrict how my personal information is used and or disclosed.

Name (please print):____Relationship to patient:______________________

Signature:____Date:______________________