Pediatric 0-2yoa Health Questionnaire

Welcome to Adjusting the World Chiropractic

Name:_____Date:_____

*Please make sure you have completed the **Patient Online Intake form from our website**. The following pages are designed to give us further information about your health and lifestyle, which will allow us to better serve you. It also includes forms requiring signatures, including privacy (HIPAA), our financial policy, and informed consent for treatment. Thank you and we look forward to serving you!*

Wellness Profile (Infant History)

Throughout the exam, the doctor will be searching for one thing: the CAUSE of your child's health challenge. Chiropractic wellness care seeks to find the causes of a health challenge, rather than simply trying to artificially alleviate the symptoms through chemical manipulation. The following questions are vital to finding the cause of your current health condition and finding solutions to your health challenge. Please take your time answering these questions, including anything that you may feel is related to your child's current complaints.

Birth History

Location: Home Birthing Center Hospital **Provider:** Midwife OB/GYN **Name of provider:** _____

Duration of Gestation: _____weeks **Duration of Birth:** _____

Please circle any that apply: Induction Forceps Vacuum Extraction C-Section

Medications given to mother during labor/delivery? Yes No If yes, what? _____

Describe any complications during or immediately after birth: _____

_____

APGAR at Birth: _____ After 5 Minutes: _____ Birth Weight: _____ Birth Length: _____

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

If no, explain: _____

Development

Has your child had any developmental delays?

Respond to Sound _____	Hold up Head _____	Crawl _____	Speak _____
Follow an Object_____	Sit Alone _____	Walk _____	

Does or did your child have any of the following:

□ Difficulty with crawling (on all fours)	□ Did not crawl on all fours	□ Difficulty using utensils
□ Difficulty learning to ride a bike	□ Appears clumsy	□ Poor hand-eye coordination

Do sleeping patterns seem normal to you? Yes No

If no, explain: _____

Number of bowel movements per day: _____ **Consistency of stools**: firm loose normal

Move Well

How does your child spend the majority of their day? **Seated Standing Other: _____**

Computer/TV use: **<30 min/day 30-60 min/day 2hr/day 3hr/day >4hr/day**

<u>Rate the following on a scale of 1-10 (10 being Best):</u>

Posture: _____

Sleep: _____ Hours per day? _____ Position_____

Does your child play outside regularly? **Yes No**

Do you believe your child gets enough physical activity? **Yes No**

Other activities: _____

Wellness Profile (continued)

Think Well

How well does your child handle stress? _____

_____

Rate the following on a scale of 1-10 (10 being Best):

Your child's stress level: _____
Daily Positive Thoughts: _____
Handle traumatic events: _____
Doing things they love: _____

Early Feeding-Eat Well

Was your child breast-fed? Yes No **How long? _____** **Any troubles with feeding?** Yes No
Formula introduced at age _____ **Solid Food at age _____**
Any food/drink allergies or intolerance? Yes No If yes, what foods: _____
During pregnancy did the mother smoke? Yes No **Drink alcohol?** Yes No **Use recreational drugs?** Yes No
Please list any illness of the mother during pregnancy: _____
Any drugs or supplements taken by the mother during pregnancy: _____
Any exposure to ultrasound? Yes No If yes, how many and what was the medical reason? _____

_____

Any invasive procedures (amniocentesis, CVS)? Yes No If yes, give reason: _____
Any smokers living in the home? Yes No **Exposure to Fluoride (water, toothpaste)?** Yes No
Child's sugar consumption (soft drinks, candy, etc.) None Low Medium High
Has your child had any vaccinations? Yes No If yes, any adverse vaccine reactions? Yes No
Which vaccinations? _____
Has your child ever taken antibiotics? Yes No If yes, how many times? _____

How many servings does your child have per day: **Fruits? ____ Vegetables? _____ Meat? _____ Dairy? _____**
How frequently does your child eat per day? **1-2 meals** **3-4 meals** **5-6 meals** **snack all day**
Drink Bottled water? **Yes** **No**
Drink Soda? (Diet or Regular) **Yes** **No**
Consume caffeine? **Yes** **No**
Do you have an air purifier? **Yes** **No**

Comments

Use this space to add any additional comments or details regarding the health of your child.

_____
_____
_____
_____

Family

At our office we are not only interested in your health and wellbeing but also that of your family and loved ones. Please mention below any **health conditions or concerns** you may have about your:

Other Children: _____ _____ **Spouse: _____**
Mother: _____ **Father: _____**
Brother(s): _____ **Sister(s): _____**

I consent to a professional and complete chiropractic examination and to any radiographic examination that the doctor deems necessary for my child. I understand that any fee for service rendered is due at the time of service and cannot be deferred to a later date.

Parent's Signature _____ Date: _____

Financial Policy

IN–NETWORK GROUP OR INDIVIDUAL INSURANCE

Your insurance is an agreement between you and your insurance company, not between your insurance company and our office. We cannot be certain if your insurance covers Chiropractic, although most policies do provide coverage. The amount they pay varies from one policy to another. We will call to verify your benefits. As a courtesy to you, our office will complete any necessary insurance forms at no additional charge, and file them with your insurance company to help you collect. It is to be understood and agreed that any services rendered, you are personally responsible for payment of any applicable deductibles, co-insurance or co-pays.

MEDICARE

We accept assignment from Medicare and we will submit your claims for you. The check is usually sent directly to our office. The ONLY services that Medicare will cover when provided by a Chiropractor is manual manipulation of the spine. Maintenance and preventative service is not covered. Medicare pays 80% of the allowable fee once the deductible has been met. You are required to pay the deductible and the remaining 20%. All other services we provide are NONCOVERED. These services include, but are not limited to, x-rays, examinations, therapies, orthotics, supports, and/or nutritional supplements. Medicare patients are fully responsible for charges of non-covered services. Maintenance and preventative service is not covered. Secondary insurance may or may not pay for these non-covered services. Please see IN-NETWORK GROUP OR INDIVIDUAL INSURANCE for payment policy.

SECONDARY INSURANCE

Please inform us of any secondary insurance.

FLEX PLANS/MEDICAL SAVINGS ACCOUNTS

If you have a flex spending account we will be happy to provide you with a statement of your charges for reimbursement. (First statement of each year is no charge. Each subsequent statement will have a $5 charge)

INSURANCE FORMS/PAYMENT

If you receive any correspondence from your insurance carrier pertaining to the care you have received at this office or a request of more information regarding your care, please bring it in as soon as possible. It is very important that we keep your file as up to date as possible. Occasionally, either by mistake, or due to provisions in your policy, the check issued by the insurance company for payment of services rendered in our office, may come to you instead of our office. If you should receive any unexpected check in the mail, please contact us to see if it does represent payment of your bill here.

PERSONAL INJURY OR AUTOMOBILE ACCIDENTS &"ON THE JOB" INJURY (Worker's Compensation)

Separate financial policies are enforced for PI and WC cases. Refer to Adjusting the World Paperwork for details.

CASH PAYING PATIENTS

If you do not fall under any of the other categories of payment, you are a **CASH** patient. Since there is no insurance to bill and there are no others responsible for your account, you are expected to pay for your visit at the time of service. You may pay with CASH, CHECK, or CREDIT CARD. We do not carry patient balances unless you have been approved for a payment plan through Care Credit, or have signed up for a monthly payment plan. For Care Credit applications and additional information on how to use Care Credit's no interest payment plans, please ask …We're happy to help!

I have read and understand the payment policy of Adjusting the World Chiropractic. I understand that my insurance is an arrangement between myself and my insurance company, NOT between Adjusting the World Chiropractic and my insurance company. I request that Adjusting the World Chiropractic prepare the customary forms at no charge so that I may obtain insurance benefits.

_____

Patient's signature (or guardian if patient is a minor) Date

_____

Witness

Informed Consent for Chiropractic Care

I will use my hands or a mechanical instrument upon your body in such a way as to move your joints. This procedure is referred to as "Spinal Manipulation or Spinal Adjustment" As the joints in your spine are moved, you may experience a "pop" as part of the process.

There are certain complications that can occur as a result of a spinal manipulation. These compilations include, but are not limited to: muscle strain, cervical myelopathy, disc and vertebral injury, fractures, strains and dislocations, Bernard-Horner's Syndrome (also known as oculosympathetic palsy), costovertebral strains and separation. Rare complications include, but are not limited to stroke. The most common complication or complaint following spinal manipulation is an ache or stiffness at the site of adjustment.

I am aware of these complications, and in order to minimize their occurrence I will take precautions. These precautions include, but are not limited to my taking a detailed clinical history of you and examining you for any defect which would cause a complication. This examination may include the use of x-rays. The use of x-ray equipment may pose a risk if you are pregnant. If you are pregnant, you should tell me when I take you clinical history.

_____

Print Name Signature Date

Consent to evaluate and adjust a minor child:

I, _____being of the parent or legal guardian of_____

_____

Signature Date

Patient Acknowledgement and Receipt of Notice of Privacy Practices Pursuant to HIPAA and Consent for Use of Health Information

The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant To HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request.

The undersign does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State law and Federal Law.

_____

Print Name Signature Date

If patient is a minor or under a guardianship order as defined by State law:

I, _____being of the parent or legal guardian of_____

_____

Signature Date