BORER FAMILY CHIROPRACTIC

Pediatric Patient Questionnaire

CONFIDENTIAL PATIENT INFORMATION

Child's name:				Today's Date:
Sex: ☐Male ☐Female	Height:	Weight:	Age:	Date of birth:
Home Address:		City:	State:	Zip:
Names and Ages of Siblings:				
Parent/Guardian Name(s):				
Home Phone:	Cell Phone:	Email:		
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:				

CURRENT HEALTH CONDITIONS

What is your present reason for consulting our office? ☐Resolve existing condition ☐Overall wellness ☐Both	
If your child has symptoms or a complaint, briefly describe the problem here:	
How and when did this problem start?	
The problem is: ☐Constant ☐Comes & Goes ☐Radiates/Travels (where?)	
What makes the problem better?	What makes the problem worse?
Please describe any past or current treatment(s) and results:	

PREGNANCY, LABOR & DELIVERY HISTORY

Did mother smoke? ☐Yes ☐No	Did mother consume alcohol? ☐Yes ☐No
Did mother take medications during pregnancy? ☐Yes ☐No	
Child's birth was: ☐Natural Vaginal birth ☐Scheduled C-section ☐Emergency C-section At how many weeks was your child born?	
Child's birth was: ☐At home ☐At a birthing center ☐At a hospital ☐Other ☐Doctor/Obstetrician's Name:	
Please check any applicable interventions or complications: ☐Breech ☐ Induction ☐Pain meds ☐Epidural ☐Episiotomy ☐Vacuum extraction ☐Forceps ☐Other	
Child's birth weight: lbs. oz	Child's birth height: in.
Please describe any other concerns or notable remarks about your child's labor and/or delivery	

TELL US ABOUT YOUR CHILD

Was your child vaccinated? ☐Yes ☐No If yes, list any vaccine reactions:

Please list any drugs/medications/vitamins/herbs/other that your child is currently taking:

List any previous medication(s), for what condition, and the number of times it was prescribed:

List any emergency/hospital visits:

List any extracurricular activities your child is/was involved with (sports/dance/etc.):

As a baby/toddler (birth – 4 years), did any of the following occur?

☐Fall from change table/crib	☐Bed Wetting	☐Tumble down the stairs
☐Involved in a car accident	☐Fall off playground equipment	☐Constipation
☐Frequent ear infections	☐Reaction to vaccination	☐Frequent fevers
☐Frequent bouts of diarrhea	☐Did not gain wait	☐Sleeping problems
☐Frequent colds	☐Colic	
☐Other:		

As a young child (5-12 years), did any of the following occur?

☐Fall from tree/playground equipment	☐Fall off a bicycle	☐Sports accident
☐Car accident	☐Stomach pains	☐Scoliosis
☐Learning difficulties	☐Bed Wetting	☐Hyperactivity/Autism
☐Asthma	☐Allergies	☐Leg/Knee Pains
☐Frequent Colds	☐Other:	

As a child or adolescent, has your child experienced any of the following?

☐Headaches	☐Arm/wrist pains	☐Foot/ankle/knee pains
☐Dizziness	☐Neck/back pains	☐Tingling in arms/legs
☐Ringing in ears	☐Sleeping problems	☐Shoulder pains
☐Asthma	☐Allergies	☐Fatigue
☐Hyperactivity	☐Stomach Problems	☐"Growing Pains"
☐Weight gain/loss	☐Other:	

Authorization

I certify that I am the parent or legal guardian listed above. I have read/understood the above information and certify it to be true and correct to the best of my knowledge. I consent to the collection and use of the above information to Borer Family Chiropractic, PLLC. I hereby give my consent to the performance of diagnostic tests and procedures and chiropractic care or management of my condition as the practitioners see fit. I hereby authorize Borer Family Chiropractic, PLLC to release all information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursement of charges incurred by me. I grant the use of my signed statement of authorization with my signature for required insurance submissions. I understand and agree that all services rendered to me will be charged to me, and I am responsible for timely payment of such services. Verifying insurance benefits does not guarantee payment from my insurance company. I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand that there is a 24-business hour cancellation policy for new patient and consultation appointments. Failure to comply with the cancellation policy may result in additional charges. A $25 fee will be applied to all NSF checks. By signing below, I agree to the financial policy described above and will adhere to all its practices.

Signature of Parent/Guardian	Parent/Guardian Name	Date Signed

Informed Consent for Chiropractic Care

I hereby give my consent to the performance of diagnostic tests and procedures and chiropractic care or management of my condition(s), on me (or on the patient named below, for whom I am legally responsible).

Chiropractic is a science and art which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may affect the restoration and preservation of health. Health is a state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.

One disturbance to the nervous system is called a vertebral subluxation. This occurs when one or more of the 24 vertebrae in the spinal column become misaligned and/or do not move properly. This causes alteration of nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by an adjustment. An adjustment is the specific application of forces to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine. Adjustments are usually done by hand but may be performed by handheld instruments. In addition, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be included.

I understand and am informed that, though infrequent, as with any health procedure, there are certain complications which may arise during chiropractic health care. These complications include, but are not limited to, soreness, fractures, disc injuries, strokes, dislocations, and sprains. These complications are extremely rare. It is not reasonable to expect the doctor to be able to anticipate and explain all risks and complications of a given procedure on any particular visit, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interest.

Neither the practice of chiropractic nor medicine is an exact science, but relies upon information related to the patient, information gathered during examination, and the doctor's interpretation thereof, as well as the doctor's judgment and expertise in working with like cases. There has been no promise, implied or otherwise, of a cure for any symptom, disease, or condition as a result of care in this office.

I understand that there are other forms of treatment, including drugs and surgery, which could be treatment options for my condition, but at this time, I choose chiropractic care.

Printed Name: _____ Signature: _____ Date: _____
Patient, parent, or legal guardian

If signed by patient representative, state relationship to patient _____

Privacy Consent

I give this practice my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies, and for health care operations like quality reviews.

I have been informed that I may review the practice's Notice of Privacy Practices (for a more complete description of uses and disclosures) before signing this consent.

I understand that this practice has the right to change their privacy practices and that I may obtain any revised notices at the practice.

I understand that I have the right to request a restriction of how my protected health information is used. However, I also understand that the practice is not required to agree to the request. If the practice agrees to my requested restriction, they must follow the restriction(s).

I also understand that I may revoke this consent at any time, by making a request in writing, except for information already used or disclosed.

Signature: _____ Date: _____

Patient, parent, or legal guardian

If signed by patient representative, state relationship to patient _____