Pediatric Patient Questionnaire

Confidential Patient Information

Child's Name: Parent/Guardian Name(s):

Street Address: City, State,Zip:

Cell Phone: Home Phone: Work Phone:

Email: Child's SS#: Birthday: Age:

How did you hear about us? Weight: Height:

Who is the primary care physician?

Emergency Contact: Emergency Relation: Emergency Phone:

How did you hear about us?

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:

Highland CHIROPRACTIC

Current Health Conditions

What health condition(s) bring you child to be evaluated by the chiropractor?

When did the condition first begin?
How did the problem start? ◯ Suddenly ◯ Gradually ◯ Post-Injury

Has your child received care for his 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?

1. _____
2. _____
3. _____

What would you like to gain from chiropractic care?

◯ Resolve existing condition(s)
◯ Overall wellness
◯ Both

Have you ever visited a chiropractor? ◯ Yes ◯ No If yes, what is their names?

Pregnancy and Fertility History

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:

Labor and Delivery History

Child's birth was: ◯ Natural vaginal birth ◯ Scheduled C-section ◯ Emergency C-section

Child's birth was: ◯ At home ◯ At a birthing center ◯ At a hospital ◯ Other Doctor's name:

Please check any applicable interventions or complications:
◯ Breech ◯ Induction ◯ Pain meds ◯ Epidural ◯ Epistolatory ◯ Vacuum extraction ◯ Forceps ◯ Other

Please describe any other concerns or notable remarks about your child's labor and/or delivery:

How many week's was your child born? Child's birth weight: Child's birth height:

APGAR score at birth: APGAR score after five minutes:

Growth and Development History

Is/was your child breastfed? ◯ Yes ◯ No If yes, how long? Difficult with breastfeeding? ◯ Yes ◯ No

Did they ever use formula? ◯ Yes ◯ No If yes, at what age? If yes, what types?

Did/does your child ever suffer from colic, reflux or constipation as an infant? ◯ Yes ◯ No
-If yes please explain:

Did/does your child frequently arch their neck, back, feel stiff, or bang their head? ◯ Yes ◯ No
-If yes please explain:

At what age did the child:
Respond to sound:
Vocalize:
Sit alone:
Walk:
Begin solid food:
Hold their head up:
Teethe:
Crawl:
Begin cow's milk:

Please list any food intolerance or allergies, and when they began:

Please list your child's hospitalization and surgical history, including this year:

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

Have you chosen to vaccinate you child? ◯ No ◯ Yes, on a delayed or selective schedule ◯ Yes, on schedule
If yes, please list any vaccination reactions:

Has you child received any antibodics? ◯ Yes ◯ No
If yes, list how many times and list reason:

DOCTOR'S NOTES

Highland Chiropractic Terms of Acceptance

Chiropractic: Chiropractic seeks to restore health through natural means without the use of medicine or surgery. This gives the body the maximum opportunity to utilize its inherent recuperative powers. The success of chiropractic depends on the environment, underlying irritants, physical and spinal problems. Like with any type of health care there are risks or complications involved. If you have concerns about your care, please speak with Dr. Ogle or Highland Chiropractic staff.

Analysis: Highland Chiropractic conducts a thorough chiropractic evaluation and utilizes the most recent research evidence and technology to develop a solution for each patient. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies are needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider.

Diagnosis: Dr. Ogle will, when necessary, refer you to other physicians for consultation and/or additional work up. While Dr. Ogle is an expert in spinal subluxations (misalignments) and misalignments throughout your body, each patient should secure on their own other opinions if the patient has additional concerns about their health.

Informed Consent: Highland Chiropractic utilizes specific techniques to evaluate and adjust patients' spinal subluxations and other misalignments throughout the body. Highland Chiropractic adjusts patients in an open setting to minimize patient wait time, to keep staff involved in patient care and to allow for easier discussion of chiropractic tenets. If the patient is uncomfortable with this style of adjusting please inform the front desk upon arriving and you will be provided with a private room.

Financial Responsibility: Highland Chiropractic works with most insurance companies. We will provide you with a complimentary insurance benefits check in our office. Verification of eligibility and/or benefit information is not a guarantee of payment for services. Any fees that are not covered by insurance will be considered the responsibility of the patient. Furthermore, the release of patient care information is authorized to any insurance company, or other health care provider involved in this case after providing proper identification information.

Personal Injury Cases: I do hereby instruct my attorney, any attorney retained in the future, or responsible insurance company to make payments directly to Highland Chiropractic. I will provide Highland Chiropractic's staff with the attorney's name, involved insurance companies, and claim numbers. I also accept responsibility for any care that is not covered by the accident claim.

Results: The purpose of chiropractic is to promote health through the reduction of subluxations or misalignments using specific chiropractic techniques. Since there are so many different variables, it is difficult to predict outcomes. 90% of our practice members see an improvement in the quality of their life, and a decrease in initial symptoms.

Media Release: I **do / do not** authorize Highland Chiropractic to publish photographs taken of me, and my name and likeness, for use in print, online and video based marketing materials as well as other company publications. I hereby release and hold harmless Highland Chiropractic from any reasonable expectation of privacy or confidentially associated with the images specified above. I further acknowledge that my participation is voluntary and that I will not receive financial compensation of any Type associated with the taking or publication of these photographs or participation in company marketing material or other company publications. I acknowledge and agree that publication of said photos confers no right of ownership or royalties.

I hereby release Highland Chiropractic, its contractors, its employees, and any third parties involved n the creation of publication of marketing materials, from liability for any claims by me or any third party in connection with my participation.

To The Patient: Please discuss any questions or concerns with Dr. Ogle or a staff member before signing this policy. By signing this I acknowledge that I have read, understand, and accept the foregoing.

Signature_____Date_____

PRIVACY POLICY: The new privacy regulations ensure a national floor of privacy protections for patients by limiting the ways that health plans, pharmacies, hospitals and other covered entities can use patients' personal medical information. The regulations protect medical records and other individually identifiable health information, whether it is on paper, in computers or communicated orally. By signing I acknowledge the receipt of this information. A complete policy is made available upon request.

Consent To Treat a Minor (if applicable)

I (we) being the parents, guardian or custodian of the minor _____, do hereby authorize Highland Chiropractic and staff to perform or order any necessary examinations, diagnostic X-rays, laboratory tests, and any treatment that in their judgment is deemed advisable or is required All charges for service and care given to said minor child will be charged directly to me (us) and I (we) will be personally responsible for payment of services rendered for them. I (we) hereby authorize the doctor to release all information necessary to secure payments of benefits. I authorized the use of this signature on all insurance submissions.

Parent, Guardian, or Custodian Signature_____Date_____