T 1 2 3

Office Use: Time _____ Team Initials _____

turning point chiropractic

New Pediatric Patient Questionnaire

Child's Full Name: _____ ○ Male ○ Female DOB: _____ Age_____

Height: _____ Weight: _____

Address: _____ City, State, Zip:_____

Other Children in the home's Names & Ages: _____

Parent(s)/Guardian(s) Name: _____

Parent Email: _____ Home Phone: _____ Work phone: _____

Parent Cell Phone: _____ Cell Provider: _____ ○ Opt in for Text Appt Reminders

What is the best number at which to reach you? ○ Home ○ Work ○ Cell

Reason for this Visit

Describe the health concern that prompted this visit: _____

What impact has this had on your child's life? _____

When did this concern begin? _____ How did this concern begin? _____

Has this condition: ○ Worsened ○ Stayed the same ○ Been intermittent Does this concern interfere with: ○ School ○ Sleep ○ Daily Activities

What makes this condition worse? _____ What makes it better? _____

Has your child seen anyone else for this concern? ○ Yes ○ No Type of treatment: _____

Does your child have regular bowel/bladder movement? ○ Yes ○ No Does your child get sick often? ○ Yes ○ No

Chiropractic Experience

How did you hear about us? _____Has your child been adjusted by a Chiropractor before? ○ Yes ○ No

If yes, what was the reason for those visits? _____ When was your last visit? _____

Has your child ever been checked for vertebral subluxation? ○ Yes ○ No Is this appointment related to ANY type of accident? ○ Yes ○ No

Is your child receiving care from other health professionals? ○ Yes ○ No If yes, please provide name & specialty: _____

Who is your family's primary care physician? _____ Please list contact information: _____

Were You Aware That...

Doctors of Chiropractic work with the nervous system? ○ Yes ○ No

The nervous system controls all bodily functions and systems? ○ Yes ○ No

Chiropractic is the largest natural healing profession in the world? ○ Yes ○ No

Health History

Often seemingly unrelated symptoms can manifest as other health concerns. Please note if your child has had any of the following:

_____ Headaches	_____ Orthopedic Problems	_____ Digestive Disorders	_____ Behavioral Problems
_____ Dizziness	_____ Neck Problems	_____ Poor Appetite	_____ ADD/ADHD
_____ Fainting	_____ Arm Problems	_____ Stomach Aches	_____ Ruptures/Hernia
_____ Seizures/Convulsions	_____ Leg Problems	_____ Reflux	_____ Muscle Pain
_____ Heart Trouble	_____ Joint Problems	_____ Constipation	_____ Growing Pains
_____ Chronic Earaches	_____ Backaches	_____ Diarrhea	_____ Asthma
_____ Sinus Trouble	_____ Poor Posture	_____ Hypertension	_____ Walking Trouble
_____ Scoliosis	_____ Anemia	_____ Colds/Flu	_____ Sleeping Problems
_____ Bed Wetting	_____ Colic	_____ Broken Bones	_____ Fall off swing
_____ Fall in baby walker	_____ Fall from bed or couch	_____ Fall from crib	_____ Fall down stairs
_____ Fall off bicycle	_____ Fall from high chair	_____ Fall off slide	____ Allergies, to: _____
_____ Fall from changing table	_____ Fall off monkey bars	_____ Fall off skateboard/skates	____ Autism Spectrum Disorder

Other: _____

Has child received any vaccinations? ○ Yes ○ No If yes, which ones and list any reactions: _____

Any reactions? _____

Has child taken any antibiotics? ○ Yes ○ No If yes, how many times and list reason: _____

Any night terrors, sleepwalking, or difficulty sleeping? ○ Yes ○ No If yes, please explain: _____

Please list all hospitalizations as well as surgical history (please include year): _____

_____

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

_____

Birth History

Child's birth was: ○ At home ○ Birth Center ○ Hospital My OB/midwife/physician was: _____

Child's birth was: ○ Vaginal ○ C-section If C-section, was it: ○ scheduled ○ emergency

If vaginal, please indicate any methods of assistance used during birth: ○ pain medication ○ epidural ○ forceps ○ vacuum ○ episiotomy

Was child born: ○ cephalic (head first) ○ breech (feet first)

Were there any complications? ○ Yes ○ No If yes, please explain: _____

Child's birth weight: _____ Child's birth height: _____ Gestational age at birth (weeks): _____

What was the duration of labor and birth? _____ hours APGAR score at birth: _____/10 After 5 minutes: _____/10

Growth & Development

Was the infant alert and responsive within 12 hours of delivery? ○ Yes ○ No If no, please explain: _____

Is/was your child breastfed? ○ Yes ○ No If yes, for how long? _____ Was your child formula fed? ○ Yes ○ No

At what age did your child:				
	Respond to sound	_____	Follow an object	_____
	Hold up head	_____	Vocalize	_____
	Sit alone	_____	Teethe	_____
	Crawl	_____	Walk	_____

Did mom smoke during pregnancy? ○ Yes ○ No Did mom drink alcohol during pregnancy? ○ Yes ○ No Smokers at home? ○ Yes ○ No

Any illnesses of mom during pregnancy? ○ Yes ○ No If yes, please explain: _____

List any drugs/medications (including over the counter) taken during pregnancy: _____

List any supplements/vitamins taken during pregnancy: _____

Health Goals

Please share a few specific health goals you have for your child.

1. _____
2. _____
3. _____
4. _____
5. _____

On a scale from 1-10 (10 being the most), how committed are you to restoring your child's health? _____

Practice Member Information (Must be completed before services can be rendered)

Patient's Name: _____
First Middle Last

Social Security Number: _____

Contact in case of emergency: _____ Phone Number: _____

Name of Primary Insurance Carrier: _____

Name of Insured: _____ Insured date of birth: _____

Insured social security number: _____

Name of Secondary Insurance Carrier: _____

Name of Insured: _____ Insured date of birth: _____

Insured social security number: _____

Insurance Policies and Fee Schedules

- **Consultation—** includes practice member history. This service is complimentary.
- **Assessment (new or established practice member)**— includes one or more of the following: thermography, surface electromyography, range of motion, postural analysis, motion and/or static palpation, leg check — $30-$100
- **Chiropractic Adjustment**— the actual correction of vertebral misalignments. A sound may or may not be heard. If there is no auditory component, it does not mean that the adjustment has not taken place. — $40-$60
- **X-Rays**— Specific x-ray views taken of your spine to determine a misalignment/subluxation of your vertebrae. These can also be used to indicate progress after a period of care. — $40+ per view

Financial Responsibility

I hereby authorize payment to be made directly to Turning Point Chiropractic, for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to Turning Point Chiropractic for any and all services I receive at this office.

_____ _____
Patient or Authorized Person's Signature Date Completed

_____
Relation to Minor

_____ _____
Doctor's Signature Date Form Reviewed

Parental Consent

I understand that I am directly and fully responsible to Turning Point Chiropractic for all fees associated with chiropractic care my child receives.

The risks associated with exposure to ionization and spinal adjustments have been explained to me to my complete satisfaction, and I have conveyed my understanding of these risks to the doctor. After careful consideration I do hereby request and authorize any necessary imaging studies, diagnostic procedures and chiropractic adjustments for the benefit of my minor child for whom I have the legal right to select and authorize health care services on behalf of.

□ Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/former spouse or other guardian is not required. If my authority to so select and authorize this care should change in any way, I will immediately notify this office.

_____ _____

Parent or Legal Guardian's Signature Date Completed

_____

Relation to Minor

_____ _____

Doctor's Signature Date Form Reviewed

REGARDING: X-rays/Imaging Studies

FEMALES ONLY: please read carefully and check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our receptionist for further explanation.

○ The first day of my female child's last menstrual cycle was on _____ (Date)

○ To the best of my knowledge, my female child is not pregnant.

By my signature below I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration I therefore, do hereby consent to any diagnostic x-ray examination the doctor has deemed necessary in my minor female child's case.

_____ _____  Witness Initials

Parent or Legal Guardian's Signature Date

○ Patient is pregnant and therefore **NOT** a candidate for x-rays at this time.

Turning Point Chiropractic NOTICE OF PRIVACY PRACTICE

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your **P**ersonal **H**ealth **I**nformation. In addition we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or as **dictated by our office policy,** we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. If you would like an additional copy, one may be requested. Once you have read this notice, please sign the last page, and return only the signature page (page 2) to our front desk receptionist. Keep this page for your records.

PERMITTED DISCLOSURES:

1. Treatment purposes - discussion with other health care providers involved in your care.
2. Inadvertent disclosures - open treating area mean open discussion. If you need to speak privately to the doctor, please let our staff know so we can place you in a private consultation room.
3. For payment purposes - to obtain payment from your insurance company or any other collateral source.
4. For workers compensation purposes - to process a claim or aid in investigation.
5. Emergency - in the event of a medical emergency we may notify a family member.
6. For Public health and safety - in order to prevent or lessen a serious or eminent threat to the health or safety of a person or general public.
7. To Government agencies or Law enforcement - to identify or locate a suspect, fugitive, material witness or missing person.
8. For military, national security, prisoner and government benefits purposes.
9. Deceased persons - discussion with coroners and medical examiners in the event of a patient's death.
10. Telephone calls or emails and appointment reminders - **we may call your home and leave messages** regarding a missed appointment or apprize you of changes in practice hours or upcoming events.
11. Change of ownership- in the event this practice is sold, the new owners would have access to your PHI.

YOUR RIGHTS:

1. To receive an accounting of disclosures.
2. To receive a paper copy of the comprehensive "Detail" Privacy Notice.
3. To request mailings to an address different than residence.
4. To request Restrictions on certain uses and disclosures and with whom we release information to, although we are not required to comply. If, however, we agree, the restriction will be in place until written notice of your intent to remove the restriction.
5. To inspect your records and receive one copy of your records at no charge, with notice in advance.
6. To request amendments to information. However, like restrictions, we are not required to agree to them.
7. To obtain **one copy** of your records at no charge, when timely notice is provided (72 hours). **X-rays** are original records and you are therefore not entitled to them. If you would like us to outsource them to an imaging center, to have copies made, we will be happy to accommodate you. However, you will be responsible for this cost.

COMPLAINTS:

If you wish to make a formal complaint about how we handle your health information, please call Dr. Leah Hetebrueg or Dr. Brooke Peters at 920.430.0280 If they are unavailable, you may make an appointment with our receptionist to see either doctor within 72 hours or 3 working days. If you are still not satisfied with the manner in which this office handles your complaint, you can submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Ave. SW
Room 509F HHH Building
Washington DC 20201

Patient initials: **_____-retaining previous page**

Turning Point Chiropractic NOTICE REGARDING YOUR RIGHT TO PRIVACY continued…

I have received a copy of Turning Point Chiropractic's Patient Privacy Notice. I understand my rights as well as the practice's duty to protect my health information, and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this "Notice of Privacy Practice" at a time in the future and will make the new provisions effective for all information that it maintains past and present.

I am aware that a more comprehensive version of this "Notice" is available to me and several copies kept in the reception area. At this time, I do not have any questions regarding my rights or any of the information I have received.

Patient's Name	DOB	HR#

Parent or Legal Guardian's Signature	Date

Relation to Minor

Witness	Date