Pediatric Patient Questionnaire

Confidential Patient Information

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

Street Address: City, State, Zip:

Home Phone: Cell Phone: Email:

Child's Sex: ❍ M ❍ F Birthdate: Age: Weight: Height:

How did you hear about us?

Who is your primary care physician?

Is your child receiving care form 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:

Current Health Conditions

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

When did the condition first begin? How did the problem start

Is this condition: ❍ Getting Worse ❍ Improving ❍ Intermittent ❍ Constant ❍ Unsure

What makes the problem better? What makes the problem worse?

What is this affecting that is MOST important in your child's life?

Has your child ever received care for this condition before? ❍ Yes ❍ No

- If yes, please explain:

Has your child ever visited a chiropractor before? ❍ Yes ❍ No

What was their specialty? ❍ Pain Relief ❍ Subluxation Based ❍ Physical Therapy & Rehab ❍ Nutritional ❍ Other ____

Pregnancy & Fertility History

Please tell us about your pregnancy ☐ Unknown/Adopted/Foster

Any fertility issues?	❍ Yes ❍ No	If yes, please explain.
Did mother smoke?	❍ Yes ❍ No	If yes, please estimate average per week?
Did mother drink?	❍ Yes ❍ No	If yes, please estimate average per week?
Did mother exercise?	❍ Yes ❍ No	If yes, please explain.
Was mother ill?	❍ Yes ❍ No	If yes, please explain.
Any ultrasound?	❍ 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

☐ Unknown/adopted/foster

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 ________________________________

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

Child's birth weight: Child's birth length:

Did/do you or was this child breastfed? ❍ Yes ❍ No Please explain:

Did/do you or was this child bottle-fed? ❍ Yes ❍ No Please explain:

At what age were these introduced: Solids ____________ Cow's milk __________

Current Health Status

The National Safety Council reports approximately 50% of children fall head first from a high place (changing table, bed, stairs, etc) during their first year. Was this the case for your child? ❍ Yes ❍ No If Yes, please explain:

Has your child ever been hospitalized or had surgery? ❍ Yes ❍ No Please explain:

Does your child have difficulty interacting with others? ❍ Yes ❍ No Please explain:

Have you ever noticed your child is nervous, twitches, shakes, or exhibits rocking behavior? ❍ Yes ❍ No Please explain:

Has your child ever been involved in any high impact/contact sports (soccer, football, cheerleading, etc) ❍ Yes ❍ No Please explain:

Are you aware of any food allergies or intolerances? ❍ Yes ❍ No Please explain:

Has your child received all recommended vaccinations? ❍ Yes ❍ No Please explain:

Please rate stress levels on a scale of 1-10 (10 being the highest)

School: 1 2 3 4 5 6 7 8 9 10 Personal: 1 2 3 4 5 6 7 8 9 10

Health Concerns

Please check any health concerns you may have for you child:

◯ Anxiety/Depression	◯ Overweight	◯ Developmental Delay	◯ Difficulty gaining weight
◯ Constipation/Diarrhea	◯ Frequent Sickness	◯ Fatigue/Sleep Issues	◯ Ear/Other Infections
◯ Nausea/Vomiting	◯ ADD/ADHD	◯ Asthma/Chronic Bronchities	◯ Headaches
◯ Diabetes	◯ Detachment/Distant	◯ Back/Neck Pain/Stiffness	◯ Learning Disorders
◯ Bed Wetting	◯ Irritability	◯ Colic/Acid Reflux	◯ Sinus Troubles/Allergies
◯ Autism/Asperger's	◯ Sensory Issues	◯ Other: __________	◯ Other: __________

Please explain any boxes checked above:

Is there anything else regarding your child's current condition you feel the doctors should know?

Health Goals

What are your top three health goals for your child?

1. ________________________________
2. ________________________________
3.

What would you like to gain from chiropractic

❍ Resolve existing condition
❍ Overall wellness
❍ Both

Permission to Treat

I, (Parent/Guardian) ______________________ give McFarland Family Chiropractic permission to examine and treat ________________________. Minor Date of Birth: ______________

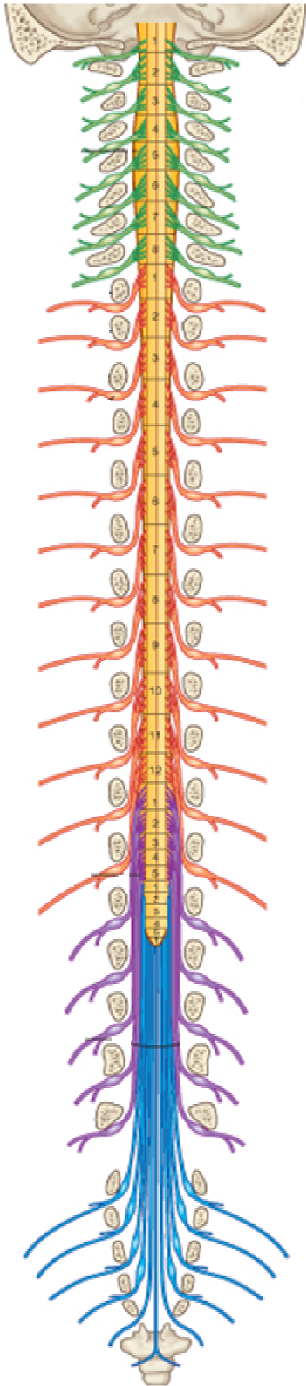
Parent/Guardian Signature: ______________________ Date: ______________________

Witness Signature: ______________________________

Patient Review of Systems

The Nervous System Controls and Coordinates all Organs and Structures of the Human Body

Please check the corresponding boxes for each symptom or condition you have experienced – ***including both PAST and PRESENT***



REGIONS	FUNCTIONS	PAST	PRESENT	SYMPTOMS	PAST	PRESENT	SYMPTOMS
Cervical	· Autonomic Nervous System · ENT Systems · Vision, Balance & Coordination · Speech · Immune System · Digestive System · Nerve Supply to Shoulders, Arms & Hands · Sympathetic Nucleus · Metabolism	☐	☐	Colic & Excessive Crying	☐	☐	Pain, numbness & tingling In arms and hands
		☐	☐	Ringing Ear	☐	☐	Epilepsy & seizures
		☐	☐	Ear & Sinus Infections	☐	☐	Sensory & spectrum
		☐	☐	Hearing Loss	☐	☐	ADD / ADHD
		☐	☐	Allergies & Congestion	☐	☐	Focus & memory issues
		☐	☐	Eye Problems	☐	☐	Anxiety & Stress
		☐	☐	Immune Deficiency	☐	☐	Nervous breakdown
		☐	☐	Headache & Migraines	☐	☐	Mental/Emotional condition
		☐	☐	Vertigo & Dizziness	☐	☐	Balance & coordination
		☐	☐	Convulsions	☐	☐	Speech Issues
		☐	☐	Sore Throat & Strep	☐	☐	TMJ / Jaw Pain
		☐	☐	Hoarseness/Laryngitis	☐	☐	Stiff Neck & Shoulders
		☐	☐	Swollen Tonsils & Adenoids	☐	☐	Depression
		☐	☐	Tonsillitis	☐	☐	High / Low Blood Pressure
		☐	☐	Vision & Hearing Issues			
		☐	☐	Low Energy (fatigue), difficulty sleeping	☐	☐	Poor Metabolism & weight control
Upper Thoracic	· Upper G.I. · Respiratory System · Cardiac Function	☐	☐	Influenza	☐	☐	Pleurisy
		☐	☐	Reflux / GERD	☐	☐	Bronchitis & Pneumonia
		☐	☐	Chronic Colds & Cough	☐	☐	Congestion
		☐	☐	Croup	☐	☐	Functional Heart Conditions
		☐	☐	Asthma	☐	☐	Difficulty Breathing
		☐	☐	Thyroid Condition	☐	☐	Shortness of Breath
Mild Thoracic	· Major Digestive Center · Detox & Immunity	☐	☐	Gallbladder Pain / Issues	☐	☐	Indigestion & Heartburn
		☐	☐	Jaundice	☐	☐	Stomach Pains & Ulcers
		☐	☐	Fever	☐	☐	Blood Sugar / Diabetes
		☐	☐	Liver Condition	☐	☐	Arthritis
Lower Thoracic	· Stress Response · Filtration & Elimination · Gut & Digestion · Hormonal Control	☐	☐	Behavior Issues	☐	☐	Allergies & Eczema
		☐	☐	Hyperactivity	☐	☐	Skin Conditions / Rash
		☐	☐	Chronic Fatigue	☐	☐	Kidney Problems
		☐	☐	Chronic Stress	☐	☐	Gas Pain & Bloating
		☐	☐	Shingles			
Lumbar, Sacrum & Pelvis	· Lower G.I. (Absorption & Motility) · Gut-Immune System · Major Hormonal Control	☐	☐	Constipation	☐	☐	Hemorrhoids
		☐	☐	Crohn's, Colitis & IBS	☐	☐	Hernias / Ruptures
		☐	☐	Diarrhea	☐	☐	Sciatica & Radiating Pain
		☐	☐	Dysentery	☐	☐	Lumbopelvic / SI Joint Pain
		☐	☐	Bed-Wetting	☐	☐	Hamstring Tightness
		☐	☐	Bladder & Urination Issues	☐	☐	Disc Degeneration
		☐	☐	Painful / Frequent Urination	☐	☐	Leg Weakness & Cramps
		☐	☐	Cramps & Menstrual Issues	☐	☐	Varicose Veins
		☐	☐	Cysts & Endometriosis	☐	☐	Poor Circulation & Cold Feet
		☐	☐	Miscarriages	☐	☐	Knee, Ankle & Foot Pain
		☐	☐	Infertility	☐	☐	Weak Ankles & Arches
		☐	☐	Change of Life Symptoms	☐	☐	Swollen Ankles
		☐	☐	Excessive Sweating	☐	☐	Lower Back Pain
		☐	☐	Impotency	☐	☐	Gluten & Casein Intolerance

Patient Name: ______________________________ Date: ______________________

HIPPA/Privacy Statement

Patient authorization regarding our open door adjusting environment, sign-in sheets, travel card use and patient record of disclosures.

Our office uses sign-in sheets, travel cards and provides care in an "open door" adjusting environment. Adjustments are done in an open adjusting area. As a result, patients are in sight of each other and some ongoing routine details of care may be in earshot of other patients and staff. This environment is used for ongoing care and is not the environment for taking patient's histories, performing examinations or presenting report of findings. These procedures are done in a private, confidential setting. If you choose not to be adjusted in an open-door adjusting environment, other arrangements will be made for you. Your signature below indicates your authorization for this activity. In addition, your signature below authorizes us to contact you at all the phone numbers/address you listed on this intake form. If you do not wish to be contacted at any listed numbers/address, please let us know.

Protecting the privacy of your personal health information is important to us. Disclosure of your personal health information without authorization is strictly limited to define 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 charges to your records. In the future, we may contact you for appointment reminders, announcements, and to inform you about our practice and its staff.

Print Patient's Name: ____ Date: ______________________

Parent/Guardian's Signature:_____________________________________ Relationship to Patient: ____________________________

Authorization for Care

I hereby authorize the doctors and staff at Health Journey Chiropractic to treat my condition as deemed appropriate. At Health Journey Chiropractic, we do not diagnose or treat any disease or condition other than vertebral subluxation and the doctor/clinic will not be held responsible for any pre-existing medical conditions. I certify the above information is correct to the best of my knowledge. I will not hold the doctors or any member of McFarland Family Chiropractic staff responsible for any errors or omission I may have in the completion of this form. Chiropractic, as well as all other types of health care are associated with potential risks in the delivery of treatment. While chiropractic treatment is remarkably safe, you need to be informed about the potential risks related to your care to allow you to be fully and therefore, as with any health care delivery system, we cannot promise a cure for any symptom, condition, or disease as a result of treatment in this office. An attempt to provide you with the very best care is our goal, and if the results are not acceptable, we will refer you to another provider who we feel can further assist you.

Parent/Guardian Signature: ____ Date: ______________________________

Referral Statement

Over 70% of our patients bring in their children to get adjusted. If you would like your children and/or spouse checked for subluxation, check the box below and they can receive a complimentary examination including computerized scan if scheduled within two weeks of starting care. **This exam is no cost to you** and does not obligate them to receive future care. We have several convenient and affordable family plan payment options should family members decide to receive care.

❍ I would like my family members checked for subluxations in the next two weeks.

Name: ____