INITIAL CHILD & ADOLESCENT QUESTIONNAIRE

Child's Name:_____ Date:_____
Birth Date:_____
Mom Name:_____ Dad Name:_____
Address:_____
_____
Telephone # Home_____ Work:_____ Cell:_____
Insurance:_____ Insured Name:_____ Insured DOB:_____

(We accept Independent Health, Empire, Nova and Aetna Insurance)

Mainly for Moms:

Tell us about your pregnancy:
Did you carry to full term?:_____
Describe any complications and when they occurred:_____
_____

Did you consume alcohol during your pregnancy:_____ How much?_____
Did you smoke?_____ How much?_____ How long?_____
Did you take any medication during your pregnancy?_____
For What?_____ What type?_____
Any exposures to ultrasound?_____How many?_____

Tell us about your delivery and birth of this child:
Did you use a midwife?_____ Hospital?_____ Obstetrician?_____
Did you have a C-Section?_____ Were forceps used?_____
Vacuum Extraction?_____ Were you induced?_____
Did you have an Epidural?_____ Was it a difficult birth?_____
What was the baby's APGAR score?_____ at 5 minutes?_____
Did you breastfeed?_____How long?_____ What formula after?_____

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

___ Fall from a changing table
___ Tumble down stairs
___ Fall out of a crib
___ Involved in car accident
___ Fall off playground equipment
___ Play in Jolly Jumper
___ Frequent ear infections
___ Tonsillitis
___ Reaction to vaccination
___Frequent crying spells
___ Frequent fevers
___ Frequent bouts of diarrhea
___ Constipation
___ Sleeping problems
___ Frequent colds
___ Colic
___ Did not gain weight
___ Other _____

Please explain the above: _____
_____

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

___ Fall from a tree
___ Fall off a bicycle
___ Fall off playground equipment
___ Sports accident
___ Car accident
___ Stomach pains
___ Scoliosis
___ Bed wetting
___ Hyperactivity/Autism
___ Learning difficulties
___ Asthma
___ Allergies
___ Leg/knee pain
___ Other _____

Please explain the above:_____

Tell us about any vaccinations your child has had:_____
_____
_____
Any reaction to any of these?_____

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

___ Headaches	___ Numbness in arms/hands	___ foot/ankle/knee pains
___ Dizziness	___ Arm/wrist pains	___ Tingling in arms/legs
___ Ringing in ears	___ Sleeping problems	___neck/back pains
___ Asthma	___ Allergies	___ Shoulder pains
___ Hyperactivity	___ Stomach problems	___ "growing pains"
___ Fatigue	___ Weight gain/loss	___ Other _____

Please explain any of the above:_____
_____

Which of the problems you have checked off is the worst?_____
Is this problem: Constant_____ Frequent_____ Occasional_____ Intermittent_____

How long has it persisted?_____
When it is at its worst, how does it make your child feel?_____
_____
What have you done about it that has NOT worked?_____
_____
What makes it worse?_____
What effect does this problem have of your child's body functions? _____
_____
_____
On his/her participation in daily activities?_____

Describe any hospital stays:_____
_____

Approximately how many times have antibiotics been prescribed and for what conditions? _____
_____
_____

List any medications our child is currently taking: _____
_____

To summarize, what is your purpose for this appointment?_____
_____
_____

Is there anything else you feel we should know?_____
_____
_____

Signature of guardian or parent:_____ **Date:**_____

Office Policies & Fees

EFFECTIVE 1/8/2018

This form outlines our office policies and expectations. By initialing on the left the patient agrees to our office policies. This form must be filled out before your initial visit.

PLEASE READ AND INITIAL THE FOLLOWING:

_____ **Payment Policy & Fees**

In order to facilitate patient visits, all payments are expected directly at the beginning of each patient visit. **Forestville Chiropractic P.C. accepts cash, check, all major credit cards and Care Credit payments only.** Checks should be made out to Forestville Chiropractic, P.C. and written prior to the start of the office visit. **Inability to provide the payment at the time of service will incur a $5 service charge for each visit not paid.** A payment receipt will be presented upon request on the day of service ONLY. If receipts are requested at a later date, they will be provided at a charge of $1 per receipt. Our fees are as follows: **$75 initial visit and $40 for follow-up appointments,** unless you have an insurance copay. An additional $15 re-evaluation fee will be charged if it has been over 6 months since your last visit. If you have not been to the office for 5 years or more, you will be considered a new patient and will be charged for an initial visit.

_____ **No Shows/Cancellations**

We reserve the right to **charge you $40** for any missed appointments without 24hrs notice. When you miss an appointment, it affects at least 3 people: The Doctor & Staff who were here ready to help you and the Patient who couldn't get in because we reserved that time for you. Please be courteous and let us know if you are unable to keep your appointment.

_____**Insurance (No Fault & Workers Comp)**

We do not accept cases due to work related injuries or auto accidents. By initialing here, the patient confirms that he/she has NOT been involved in a work-related accident or motor vehicle accident. Patient is also aware that their primary insurance company may NOT be billed for treatment following such injuries as it constitutes insurance fraud. If you've been involved in such an accident, please let us know at the front desk or give us a call if you are filling this form out other than our office and we'll be happy to refer your case to another practitioner.

_____ **HIPAA Acknowledgement of Consent** (please choose a box below)

By signing below, I hereby acknowledge that I have been provided with access to a posted copy of this office's Notice of Privacy Practices and have therefore been advised of how my protected health information may be used and disclosed by the office and how I may obtain access to and control this information. This form is available in our office waiting room, in print form by request at the front desk and on our website forestvillechriopractic.com. I understand that Forestville Chiropractic P.C. has the right to change its Notice of Privacy Practices from time to time and I may contact this organization at any time to obtain a current copy of the Notices of Privacy Practices.

- ☐ I have been given the right to review such Notice of Privacy Practices and would request a copy for my review.
- ☐ I have been given the right to review such Notice of Privacy Practices and decline a copy for my review today, but may request a copy at any time.

In addition, by signing below, I hereby consent to use and disclose of my health information for treatment purposes, payment activities, and healthcare operations of the office as described in the Notice.

Signature: _____ Date:_____