INITIAL CHILD & ADOLESCENT QUESTIONNAIRE

Child's Name: (First)_____(Middle Initial)_____(Last)_____
Birth Date: _____Social Sec #: _____
Mom Name:_____ Dad Name:_____
Address:_____(City) _____(State)____(Zip) _____
Telephone # (Home) _____Parent Cell: (mom) _____ (dad)_____
Insurance Carrier: _____ Policy Holder Name: _____
Policy holder DOB: _____Relation to Policy Holder: (Check) ☐ Child ☐ Other

Mainly for Moms:
Tell us about your pregnancy:
Did you carry to full term? ☐Yes ☐No Describe any complications and when they occurred: _____

_____

Did you consume alcohol during your pregnancy: ☐Yes ☐No How much? _____

Did you smoke? ☐Yes ☐No How much? _____ How long? _____

Did you take any medication during your pregnancy? ☐Yes ☐No

For What?_____ What type?_____

Any exposures to ultrasound? ☐Yes ☐No How many? _____

Tell us about your delivery and birth of this child:
Did you use a midwife? ☐Yes ☐No Hospital? ☐Yes ☐No Obstetrician? _____

Did you have a C-Section? ☐Yes ☐No Were forceps used? ☐Yes ☐No Vacuum Extraction? ☐Yes ☐No

Were you induced? ☐Yes ☐No Did you have an Epidural? ☐Yes ☐No Was it a difficult birth? ☐Yes ☐No

What was the baby's APGAR score? _____ at 5 minutes? _____

What formula after? _____Breast fed? ☐Yes ☐No ☐Bottle & Breast

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

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

Please explain any of the above:

_____

_____

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

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

Please explain any of the above:

_____

_____

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_____

When did the symptoms start? _____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? _____

How long is the child on a electronic Device? _____

Tell us about any vaccinations your child has had: _____

_____

_____

Any reaction to any of these? _____

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 01/01/2019

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, **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. **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. An additional 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 12- 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 in advance 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 during your care, 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: _____

Forestville Chiropractic, P.C.

Financial Policy

Patient Name_____ Date of Birth _____

Forestville Chiropractic, P.C. appreciates the confidence you have shown in choosing us to provide for your health care needs. The service you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill.

You are responsible for payment of any deductible and co-payment/co-insurance as determined by your contract with your insurance carrier. We expect these payments at time of service. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurer. If your insurance carrier denies any part of your claim, or if you or your physician elects to continue past your approved period, you will be responsible for your balance in full.

I have read the above policy regarding my financial responsibility to Forestville Chiropractic, P.C., for providing chiropractic services to me or the above-named patient. I certify that the information is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to Forestville Chiropractic, P.C., the full and entire amount of bill incurred by me or the above-named patient; or, if applicable any amount due after payment has been made by my insurance carrier.

Patient Signature _____ Date _____

Guarantor Signature _____ Date _____
(If guarantor is not the patient)

Consent for Treatment and Authorization to Release Information

I hereby authorize Forestville Chiropractic, P.C., through its appropriate personnel, to perform or have performed upon me, or the above-named patient, appropriate assessment and treatment procedures.

I further authorize Forestville Chiropractic, P.C., to release to appropriate agencies, any information acquired in the course of my or the above-named patient's examination and treatment.

Patient/Guarantor Signature _____ Date _____

Insurance Information:

Insurance Company: _____
Policy#/Group# _____
Name of Policy Holder: _____
Relation to Patient: _____
Date of birth for Policy Holder _____

Is patient covered by additional Insurance? ☐ Yes ☐ No

- Subscriber's Name _____
- Birthdate of policy holder_____
- Relationship to patient: _____
- Insurance Company Name: _____
- Policy#/Group#_____