ChiropracticWellness

New Patient Questionnaire — Pediatric (0-7)

Please fill out this form, in its entirety, in blue or black ink

Today's Date:_____

Patient Information

Child's Full Name:_____ Prefers to be called:_____
Address:_____ City, State, Zip:_____
Date of Birth: ___/___/_____ Age:_____ SSN:_____ Gender at birth:_____

Guardian Information

1. Parent/Guardian Name and Phone:_____
Employer:_____ Work Address:_____
2. Parent/Guardian Name and Phone: _____
Employer:_____ Work Address:_____
Parent/Guardian E-Mails (we will not give out to others): _____
How did you hear about us? _____

What conditions are you seeking treatment for? (colic, constipation, ear infection, back pain etc.)

Describe Condition 1._____
How did this condition develop?_____
Date of Onset:_____ Other treatment for this condition: _____

- Is this condition... getting worse / improving / intermittent / constant / unsure
- What percentage of time are symptoms present? 0% 25% 50% 75% 100%
- Is it interfering with... [ ] Sleep [ ] Daily Routine [ ]Eating [ ] Developmental Milestones
- What makes it better?_____ What makes it worse?_____

Describe Condition 2._____
How did this condition develop?_____
Date of Onset:_____ Other treatment for this condition:_____

- Is this condition... getting worse / improving / intermittent / constant / unsure
- What percentage of time are symptoms present? 0% 25% 50% 75% 100%
- Is it interfering with... [ ] Sleep [ ] Daily Routine [ ]Eating [ ] Developmental Milestones
- What makes it better?_____ What makes it worse?_____

Describe Condition 3._____
How did this condition develop?_____
Date of Onset:_____ Other treatment for this condition:_____

- Is this condition... getting worse / improving / intermittent / constant / unsure
- What percentage of time are symptoms present? 0% 25% 50% 75% 100%
- Is it interfering with... [ ] Sleep [ ] Daily Routine [ ]Eating [ ] Developmental Milestones
- What makes it better?_____ What makes it worse?_____

Pregnancy and Labor/Delivery: write NONE or please list/explain

Concerns during Fertility/Pregnancy/Ultrasounds?: _____
_____
Did mother experience any illnesses, injuries, or heatlh concerns like pre-eclampsia?:_____

Any notable mental/physical stress during pregnancy? _____
Was the birth... Vaginal / scheduled C-section / emergency C-section?
Please circle all interventions performed:
Breech Induction Epidural Episiotomy Vacuum Extraction Forceps Other_____
Gestational weeks at birth? _____ weeks Birth Weight: _____
Any concerns immediately post-delivery? _____

ChiropracticWellness

New Patient Questionnaire — Pediatric (0-7)

Medical History: write NONE or please list/explain

Previous surgeries/hospitalizations: _____

_____

Previous Accidents/injuries: _____

_____

Any known allergies or intolerances?: _____

Primary Pediatrician: _____

Is the child receiving care from any other professional? (Y / N) Name & Specialty

_____

Medications/Supplements: _____

_____

Vaccines? [ ] On Schedule [ ] Delayed Schedule [ ] Do Not Vaccinate

Has your child ever received antibiotics? (Y / N) If yes, # of doses and what for?: _____

Growth and Development History

Was the child breastfed? (Y / N) If yes, how long? _____ Difficulty (Y / N)
Did they ever use formula? (Y / N) If yes, how long? _____ Type _____
Describe your child's current diet: _____
Current Sports/Hobbies: _____

Please mark any of the below conditions for your child at birth/newborn stage:

___ Jaundice ___ Distorted skull/flat head ___ Head Bruising ___ Colic

___ Difficulty with latching ___ Difficulty with tummy time ___ Did not sit up by 6 months

___ Abnormal/Didn't Crawl by 9 months ___ Difficulty changing positions ___ Difficulty holding head up

____Difficulty with eating/digestion ___ Lip or Tongue Tie ___ Took any medications

Please mark any of the below symptoms you have noticed in your child:

___ Prefers rocking motion ___ Child bangs their head ___ Sucking thumb past age 5

___ Wet bed past age 5 ___ Abnormal gait/walk ___ Late walker ____ Late talker

___ Difficulty with stairs ___ Motion Sickness ___ Allergies ___ Asthma

___ Eczema ___ Congestion ___ Difficulty getting dressed or tying shoes

___ Over-reaction or under-reaction to sounds and circumstances ___ Hyperactive/can't sit still

___ Difficulty riding a bike, catching a ball, or learning to swim

___ Difficulty with textures (food) ___ Difficulty with textures (touch) ___ Easily distracted/difficulty with focus

___Difficulty sleeping ___ Night Terrors ___ Behavioral, Emotional, or Social Issues

ChiropracticWellness

New Patient Questionnaire

Pediatric (0-7)

Please mark any of the academic delays you have noticed in your child:

___ Learning issues ___ Difficulty telling time ___ Bad handwriting ___ Reading issues

___ Math issues ___ Difficulty learning new skills ___ Speech delays

___ Difficulty getting out words and/or saying certain letters/sounds/stutter

___ Trouble establishing hand dominance, crossing midline, or doing various tasks with hands

___ Awkward pencil grip ___ Numerous mistakes copying from a board

___ Make up words or phrases while reading ___ Miss or disorganize letters or numbers

___ Difficulty recalling names of objects, details or information ___ Difficulty understanding multiple step directions

Please mark if your child has any of the following diagnoses:

___ ADD ___ ADHD ___ Dyslexia ___ Autism/Autism Spectrum ___ SPP ___ Seizures

___ Recurring ear infections ___ Swollen tonsils and adenoids

Please list any illnesses and/or development delays your child has had not previously listed above:

_____

Consent of Examination of Minor

I, the undersigned, do hereby authorize Dr. Jennifer C. Daniel-Price, D.C. and/or any other licensed chiropractic physicians and assistants employed by Chiropractic Wellness Connection under their supervision, to perform examination, diagnostic tests, diagnosis and render necessary treatment as deemed necessary by the doctor to minor child.

Patient's Name_____

Parent/Guardian Signature _____ Date: _____

Payment Information:

□ I currently have BCBS or Medicare. I give full authorization to Chiropractic Wellness Connection and its employees to do and release all that is necessary to have the insurance payments covered. I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I do know that I am ultimately responsible for any balance on my account.

*CWC will need a copy of your insurance card and all the insured's information in order to bill today.

□ I have other insurance and would like a receipt that I can send to my insurance company myself for possible reimbursement. I know that I am responsible for any balance on my account.

□ I have a worker's compensation, automobile accident or other personal injury account and claim that has been opened and is current. I am seeking treatment for injuries directly related from this accident. I know that I am responsible for any balance on my account.

□ I do not have insurance benefits and will be paying as a cash patient. I am fully responsible for my account.

Patient Name:_____ Today's Date:_____

Signature of Parent/Gaurdian:_____

Jennifer Daniel-Price, D.C.
Chiropractic Wellness Connection
410 E. Elm St. Canton, IL 61520
Phone: 309-647-7490

Communication Regarding Confidential Information

In order for us to keep communication regarding your information confidential, we need the following:

Mark below the means by which you authorize us to contact you. MARK ALL THAT APPLY. Write N/A if you do not want that form of communication.

- ☐ Call Home at this phone number: _____
- ☐ Call Cell at this phone number: _____
- ☐ Text Cell at this phone number: _____
- ☐ Email address: _____

Do you want appointment reminders sent to you? Yes _____ No _____
If yes, how would you like your reminder? Text to Cell phone _____ E-mail _____

May we leave a message and/or talk with another party on your behalf? Yes _____ No _____
Please list authorized person(s) to receive protected health information on your behalf:

Name: _____ Relationship: _____ Phone Number: _____

Name: _____ Relationship: _____ Phone Number: _____

Please list any other special requests regarding your health information: _____
_____

I, the undersigned, hereby acknowledge that by signing this Consent:

1. I am aware that the Practice's Privacy Notice is available to me upon request. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information (PHI) necessary for the practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out health care operations. The Privacy Notice is also available to me in the future at my request. The Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to signing this Consent.
2. The practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable laws.
3. The Practice's "Notice of Privacy Practices" is provided at 410 E. Elm St., Canton, IL 61520. I may also request a copy from this office at any time directly from the office or via US Mail.
4. This Notice of Privacy Practices also describes my rights and the duties of this office with respect to my protected health information.

Patient's Name (please print): _____

Signature: _____ Date: _____

If you are not the patient, please specify your name and relationship to the patient:
_____

Informed Consent to Care

You are the decision maker for your health care. "Informed consent" involves your understanding and agreement regarding the care we recommend,risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

CHIROPRACTIC TREATMENT involves the management of conditions by means of a chiropractic adjustment, a specific type of joint manipulation performed by hand or instrument with person to person contact. The chiropractic adjustment carries a plethora of benefits but also has risks associated with it. Results are not guaranteed.

Serious risks and side effects associated with the chiropractic adjustment are extremely rare but include the following:.

Temporary soreness, muscle spasm, increased pain, dizziness, headache, nausea and increased other symptoms: It is not uncommon for the patients to experience temporary soreness, muscle spasm, headache or increased symptoms or pain after treatments especially with beginning care. It is less likely to experience dizziness and nausea post treatment.

Fractures: When patients have underlying conditions and/or treatments that weaken bones, they may be susceptible to fracture. It is important to notify your chiropractor if you have been diagnosed with a bone weakening condition and/or medical treatment. If your chiropractor detects any such condition while you are under care, you will be informed and your treatment plan will be modified to minimize risk of fracture.

Disc herniation or prolapse: Spinal disc conditions like bulges or herniations may worsen with chiropractic care. It is important to notify your chiropractor if symptoms change or worsen.

Stroke: There is an extremely rare association with stroke and certain types of chiropractic care. This is a very debatable topic as any stroke can occur from a multitude of reasons and the timing can be spontaneous and unknown until the event has occurred no matter the cause. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Patients who are experiencing a stroke may or may not have initial symptoms. We do our best to determine the possibility and risk of stroke with every patient at every visit. There may be times when chiropractic treatment is not given and medical testing is advised instead.

Other possible risks: Other possible risks include but are not limited to bruising, disruptions of internal medical devices, dislocations, and/or sprains and strains. If any of these conditions or symptoms occur, notify your chiropractor immediately.

It is important to know that it is not possible to know every potential complication to care. It is important to notify the chiropractor immediately if you experience these symptoms or any adverse symptoms during or after your care. Your chiropractor has the right to refuse treatment in the event that they have concern with your current condition and do not advise treatment accordingly.

ACUPUNCTURE treatment is a form of therapy in which fine needles are inserted into specific points on the body. Acupuncture is generally very safe and serious side effects are very rare. Acupuncture may be contraindicated on certain patients so notify chiropractor before treatment if you have any of the following: are pregnant, have a pacemaker or other electrical implant, bleeding disorder, blood borne pathogens, or are taking anticoagulants or any other medications. It is important to not move during the insertion, retention, or removal of the needles.

The following are known risks with **acupuncture care:**

Drowsiness and dizziness may occur after treatment in a small number of patients, and, if affected, you are advised not to drive.

Minor bleeding, bruising, pain , temporary worsening of symptoms, numbness and tingling, and/or muscle contractions may occur after treatment.

Infection is another possible risk, although the chiropractor uses sterile, single use, disposable needles.

It is important to know that it is not possible to consider every possible complication to any type of care.

It is also important that you understand there are treatment options available for your condition other than chiropractic and acupuncture procedures. These options may include, but are not limited to: self-administered care, over the counter pain relievers, rest, medical treatment, physical therapy, bracing, injections, and surgery. You have the right to a second opinion and trying other options in healthcare as you see fit.

I have read, or had read to me, the above consent. I have discussed any questions or concerns with my chiropractor and/or their staff , have had these answered to my satisfaction prior to my signing this document and acknowledge that no guarantee can be given as to the results or outcome of my care. I have made my decision voluntarily and freely. I hereby give my consent to the performance of diagnostic tests, procedures and chiropractic treatment, acupuncture treatment and physical modalities recommended by my chiropractor and/or management of my conditions.

Patient Name: Signature:

_____ _____ Date:_____

Parent or Guardian: Signature:

_____ _____ Date:_____

Witness Name: Signature:

_____ _____ Date:_____