

# Pediatric Patient Questionnaire

## Confidential Patient Information

Child's Name:	Parent/Guardian Name(s):		
Street Address:	City, State, Postal Code:		
Cell Phone:	Other Phone:	Child's Sex:	
Email:	Child's SSN:	Birthdate:	Age:
How did you hear about us?	Height:	Weight:	
Who is your primary care physician?			
Is your child receiving care from any other health professionals? <input type="radio"/> Yes <input type="radio"/> No – If yes, please name them and their specialty:			
Please list any drugs/medications/vitamins/herbs or other that your child is taking:			

## Current Health Conditions

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

When did the condition first begin? \_\_\_\_\_ How did the problem start?  Suddenly  Gradually  Post-Injury

Has your child ever received care for this condition?  Yes  No  
– If yes, please explain: \_\_\_\_\_

Is this condition:  Getting worse  Improving  Intermittent  Constant  Unsure

What makes the problem better? \_\_\_\_\_ What makes the problem worse? \_\_\_\_\_

## Health Goals for Your Child

What are your top three health goals for your child? \_\_\_\_\_ What would you like to gain?

1. \_\_\_\_\_  Resolve existing condition

2. \_\_\_\_\_  Overall wellness

3. \_\_\_\_\_  Both

Has your child ever visited a chiropractor?  Yes  No – If yes, what is their name: \_\_\_\_\_

– What is their specialty:  Pain Relief  Physical Therapy & Rehab  Nutrition  Subluxation-based  Other: \_\_\_\_\_

## Pregnancy & Fertility History

Please tell us about your pregnancy:

Any fertility issues?  Yes  No If yes, please explain: \_\_\_\_\_

Did mother smoke?  Yes  No If yes, how often? \_\_\_\_\_

Did mother drink?  Yes  No If yes, how often? \_\_\_\_\_

Did mother exercise?  Yes  No If yes, please explain: \_\_\_\_\_

Was mother ill?  Yes  No If yes, please explain: \_\_\_\_\_

Any ultrasounds?  Yes  No If yes, please explain: \_\_\_\_\_

Please explain any noticeable 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 & Delivery History

Child's birth was:  Natural vaginal birth  Scheduled C-section  Emergency C-section – At how many weeks was your child born?

Where was your child born? \_\_\_\_\_ – Who delivered your baby? \_\_\_\_\_

Please indicate 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 height: \_\_\_\_\_ APGAR score at birth: \_\_\_\_\_ APGAR score after 5 min.: \_\_\_\_\_

## Growth & Development History

Is/was your child breastfed?  Yes  No – If yes, how long? \_\_\_\_\_ Difficulty with breastfeeding?  Yes  No

Did they ever use formula?  Yes  No – If yes, at what age? \_\_\_\_\_ – If yes, what type? \_\_\_\_\_

Did/does your child suffer from colic, reflux, or constipation as an infant?  Yes  No

– If yes, please explain: \_\_\_\_\_

Did/does your child frequently arch their neck/back, feel stiff, or bang their head?  Yes  No

– If yes, please explain: \_\_\_\_\_

At what age did the child: Respond to sound: \_\_\_\_\_ Follow an object: \_\_\_\_\_ Hold their head up: \_\_\_\_\_ Vocalize: \_\_\_\_\_

Teeth: \_\_\_\_\_ Sit alone: \_\_\_\_\_ Crawl: \_\_\_\_\_ Walk: \_\_\_\_\_ Begin cow's milk: \_\_\_\_\_ Begin solid foods: \_\_\_\_\_

Please list any food intolerance or allergies, and when they began: \_\_\_\_\_

Please list your child's hospitalization and surgical history (including the year): \_\_\_\_\_

Please list any major injuries, accidents, falls and/or fractures your child has sustained in his/her lifetime (including the year): \_\_\_\_\_

Have you chosen to vaccinate your child?  No  Yes, on a delayed or selective schedule  Yes, on schedule

– If yes, please list any vaccine reactions: \_\_\_\_\_

Has your child received any antibiotics?  Yes  No

– If yes, how many times and list reason: \_\_\_\_\_

Night terrors or difficulty sleeping?  Yes  No – If yes, please explain: \_\_\_\_\_

Behavioral, social or emotional issues?  Yes  No – If yes, please explain: \_\_\_\_\_

How many hours per day does your child typically spend watching TV, computer, tablet or phone? \_\_\_\_\_

How would you describe your child's diet?  Mostly whole, organic foods  Pretty average  High amount of processed foods

## Acknowledgement & Consent

Parent/Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_

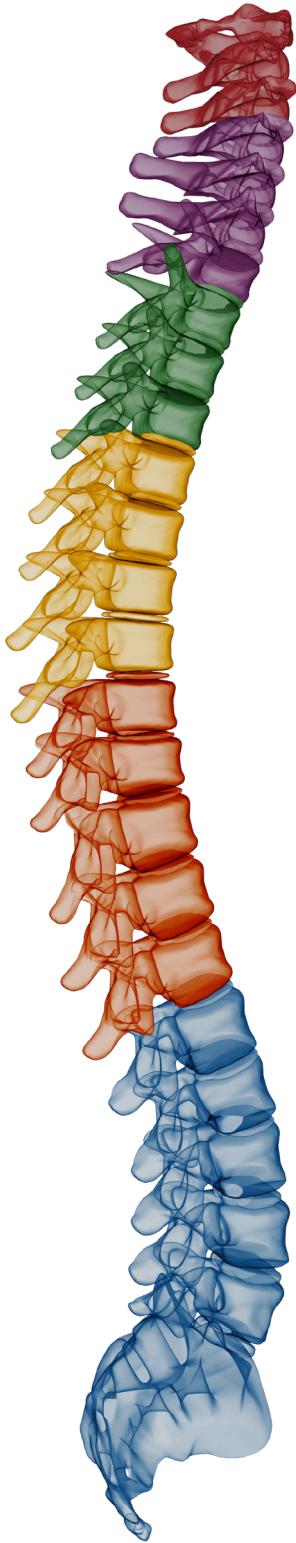
### Cafe of Life Chiropractic

2439 Grand Avenue, Bellmore, NY, 11710 | 100 W Park Avenue, Long Beach, NY, 11561  
516-425-0113 | cafeoflifebellmore@hotmail.com | cafeoflife.com

# 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	SYMPTOMS					
		PAST	PRESENT				
<b>Cervical</b>	• Autonomic Nervous System	<input type="checkbox"/>	<input type="checkbox"/>	Colic & Excessive Crying	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy & Seizures
	• ENT System	<input type="checkbox"/>	<input type="checkbox"/>	Ear & Sinus Infections	<input type="checkbox"/>	<input type="checkbox"/>	Sensory & Spectrum
	• Vision, Balance & Coordination	<input type="checkbox"/>	<input type="checkbox"/>	Allergies & Congestion	<input type="checkbox"/>	<input type="checkbox"/>	ADD / ADHD
	• Speech	<input type="checkbox"/>	<input type="checkbox"/>	Immune Deficiency	<input type="checkbox"/>	<input type="checkbox"/>	Focus & Memory Issues
	• Immune System	<input type="checkbox"/>	<input type="checkbox"/>	Headaches & Migraines	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety & Stress
	• Digestive System	<input type="checkbox"/>	<input type="checkbox"/>	Vertigo & Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Balance & Coordination
	• Nerve Supply to Shoulders, Arms & Hands	<input type="checkbox"/>	<input type="checkbox"/>	Sore Throat & Strep	<input type="checkbox"/>	<input type="checkbox"/>	Speech Issues
	• Sympathetic Nucleus	<input type="checkbox"/>	<input type="checkbox"/>	Swollen Tonsils & Adenoids	<input type="checkbox"/>	<input type="checkbox"/>	TMJ / Jaw Pain
	• Metabolism	<input type="checkbox"/>	<input type="checkbox"/>	Vision & Hearing Issues	<input type="checkbox"/>	<input type="checkbox"/>	Stiff Neck & Shoulders
		<input type="checkbox"/>	<input type="checkbox"/>	Low Energy & Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Depression
		<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Sleeping	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure
		<input type="checkbox"/>	<input type="checkbox"/>	Pain, Numbness & Tingling in Arms to Hands	<input type="checkbox"/>	<input type="checkbox"/>	Poor Metabolism & Weight Control
	<b>Upper Thoracic</b>	• Upper G.I.	<input type="checkbox"/>	<input type="checkbox"/>	Reflux / GERD	<input type="checkbox"/>	<input type="checkbox"/>
• Respiratory System		<input type="checkbox"/>	<input type="checkbox"/>	Chronic Colds & Cough	<input type="checkbox"/>	<input type="checkbox"/>	Functional Heart Conditions
• Cardiac Function		<input type="checkbox"/>	<input type="checkbox"/>	Asthma			
<b>Mid Thoracic</b>	• Major Digestive Center	<input type="checkbox"/>	<input type="checkbox"/>	Gallbladder Pain / Issues	<input type="checkbox"/>	<input type="checkbox"/>	Indigestion & Heartburn
	• Detox & Immunity	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Pains & Ulcers
		<input type="checkbox"/>	<input type="checkbox"/>	Fever	<input type="checkbox"/>	<input type="checkbox"/>	Blood Sugar Problems
<b>Lower Thoracic</b>	• Stress Response	<input type="checkbox"/>	<input type="checkbox"/>	Behavior Issues	<input type="checkbox"/>	<input type="checkbox"/>	Allergies & Eczema
	• Filtration & Elimination	<input type="checkbox"/>	<input type="checkbox"/>	Hyperactivity	<input type="checkbox"/>	<input type="checkbox"/>	Skin Conditions / Rash
	• Gut & Digestion	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Problems
	• Hormonal Control	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Stress	<input type="checkbox"/>	<input type="checkbox"/>	Gas Pain & Bloating
<b>Lumbar, Sacrum &amp; Pelvis</b>	• Lower G.I. (Absorption & Motility)	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>	Sciatica & Radiating Pain
	• Gut-Immune System	<input type="checkbox"/>	<input type="checkbox"/>	Chrohn's, Colitis & IBS	<input type="checkbox"/>	<input type="checkbox"/>	Lumbopelvic / SI Joint Pain
	• Major Hormonal Control	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	Hamstring Tightness
		<input type="checkbox"/>	<input type="checkbox"/>	Bed-wetting	<input type="checkbox"/>	<input type="checkbox"/>	Disc Degeneration
		<input type="checkbox"/>	<input type="checkbox"/>	Bladder & Urination Issues	<input type="checkbox"/>	<input type="checkbox"/>	Leg Weakness & Cramps
		<input type="checkbox"/>	<input type="checkbox"/>	Cramps & Menstrual Issues	<input type="checkbox"/>	<input type="checkbox"/>	Poor Circulation & Cold Feet
		<input type="checkbox"/>	<input type="checkbox"/>	Cysts & Endometriosis	<input type="checkbox"/>	<input type="checkbox"/>	Knee, Ankle & Foot Pain
		<input type="checkbox"/>	<input type="checkbox"/>	Infertility	<input type="checkbox"/>	<input type="checkbox"/>	Weak Ankles & Arches
		<input type="checkbox"/>	<input type="checkbox"/>	Impotency	<input type="checkbox"/>	<input type="checkbox"/>	Lower Back Pain
		<input type="checkbox"/>	<input type="checkbox"/>	Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>	Gluten & Casein Intolerance

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

# HIPAA Compliance *Patient Consent Form*

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your Personal Health Information. 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. Once you have read this notice, please sign and return to our front desk receptionist.

## 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 apprise 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 contact our office. 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**

*I have received a copy of Chiropractic's Patient Privacy Notice. I understand my rights as well as the practices 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 an 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. At this time, I do not have any questions regarding my rights or any of the information I have received.*

May we discuss your medical condition with any member of your family?  Yes  No

If yes, please name family members allowed: \_\_\_\_\_

This consent was signed by: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone Number: \_\_\_\_\_

# Informed Consent for Chiropractic Care

We encourage and support a **shared decision making process** between us regarding your health needs. As a part of that process you have a right to be informed about the condition of your health and the recommended care and treatment to be provided to you so that you can make the decision whether or not to undergo such care with full knowledge of the known risks. This information is intended to make you better informed in order that you can knowledgeably give or withhold your consent.

Chiropractic is based on the science which concerns itself with the relationship between structures (primarily the spine) and function (primarily the nervous system) and how this relationship can affect the restoration and preservation of health.

**Adjustments** are made by chiropractors in order to correct or reduce spinal and extremity joint subluxations. **Vertebral subluxation** is a disturbance to the nervous system and is a condition where one or more vertebra in the spine is misaligned and/or does not move properly causing interference and/or irritation to the nervous system. The primary goal in chiropractic care is the removal and/or reduction of nerve interference caused by vertebral subluxation.

A chiropractic examination will be performed which may include spinal and physical examination, orthopedic and neurological testing, palpation, specialized instrumentation.

The chiropractic adjustment is the application of a precise movement and/or force into the spine in order to reduce or correct vertebral subluxation(s). There are a number of different methods or techniques by which the chiropractic adjustment is delivered but are typically delivered by hand. Some may require the use of an instrument or other specialized equipment. Among other things, chiropractic care may reduce pain, increase mobility and improve quality of life.

In addition to the benefits of chiropractic care and treatment, one should also be aware of the existence of some risks and limitations of this care. The risks are seldom high enough to contraindicate care and all health care procedures have some risk associated with them.

Risks associated with some chiropractic treatment may include soreness, musculoskeletal sprain/strain, and fracture. In addition there are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke; rather, recent studies indicate that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence, there is a stroke already in process. However, you are being informed of this reported association because a stroke may cause serious neurological impairment.

**I have been informed of the nature and purpose of chiropractic care, the possible consequences of care, and the risks of care, including the risk that the care may not accomplish the desired objective. Reasonable alternative treatments have been explained, including the risks, consequences and probable effectiveness of each. I have been advised of the possible consequences if no care is received. I acknowledge that no guarantees have been made to me concerning the results of the care and treatment.**

I HAVE READ THE ABOVE PARAGRAPH. I UNDERSTAND THE INFORMATION PROVIDED. ALL QUESTIONS I HAVE ABOUT THIS INFORMATION HAVE BEEN ANSWERED TO MY SATISFACTION. HAVING THIS KNOWLEDGE, I KNOWINGLY AUTHORIZE THIS OFFICE TO PROCEED WITH CHIROPRACTIC CARE AND TREATMENT.

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Patient Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Guardian Signature (for minor): \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

- In addition, I give my permission for the above named minor patient to be managed by the doctor even when I am not present to observe such care.