CAROLINASCHIROPRACTIC
AND SPINAL REHAB

Pediatric Patient Information & Health Questionnaire

Patient Information

Full Name: ______________________________________ Date: ____________
First MI Last

Address: ______________________ City: ______________ State: ______ Zip: __________

Age: __________ Birth Date: ____________ Female: ___ Male: ___ Height: ________ Weight: ________

Home Phone: ____________________ Parent's Cell/Other: ____________________

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

☐ Email Confirmation ☐ Text Message to my Cell Phone: **Please list your cell phone carrier:** ____________

Parent/ Guardian Information

Name: ________________ Birth Date: __________ Email Address: ________________

Employer: ____________________ Occupation: ____________________

How did you hear about our office? ______________________________

Health Questionnaire

Reason for Visit: ______________________________

Name of Pediatrician: ______________ Phone Number: __________ Date of Last Visit: __________

When doctors work together it benefits you. May we have your permission to update your pediatrician regarding your child's care at this office? (check one) Yes ___ No___

Have you seen other doctors for this condition? Yes___ No____. Please list doctors' names and prior treatments:

____

Are there any other health problems/ concerns? ______________________________

Check any of the following conditions your child has suffered from during the past six months:

__Ear Infections __Asthma/Allergies __Digestive Problems __ADHD __Bed Wetting __Seizures __Difficulty Sleeping

__Chronic Colds __Car Accident __Recurring Fever __Temper Tantrums __Scoliosis __Back Pain __Growing Pains

__Headaches __Other: __________

Prescriptions child is taking: ______________________________

Does child have any allergies? ______________________________

Is there any position your child does not like (turning head to right, lying on back, etc)? ______________

Is there any family history of childhood/genetic disease? ______________

Developmental History

During your child's development their spine is the most vulnerable to physical stress. Regular check-ups by a Doctor of Chiropractic are recommended for the well-being of their growing spine and nervous system.

Did you notice any differences, difficulties or skipping of some of the following stages (if applicable):

__Response to Sound __Hold Head Up __Sit Up __Rolling Over __Self Feeding __Walking Alone __Cross Crawl __Stand Alone __Walking Alone __Talking

Is/has your child been involved in any high impact or contact type sports (i.e. Soccer, Football, Gymnastics, Cheerleading,

Martial Arts, etc)? If yes, please list: ____________________

Has your child had previous chiropractic care? ___Yes___No If yes, please list last visit date:____________

Has your child ever been involved in a car accident? __Yes __No If yes, please list date:____________

Prior Surgeries? __Yes __No If yes, please list surgery type and date:____________

Prior Hospitalization? __Yes __No If yes, please hospitalization list type and date:____________

Are there any other parental concerns?____________

Childhood Diseases (Please circle all that apply): Chicken Pox, Measles, Mumps, Rubella, Whooping Cough, Other:____________

Payment Information

Please have your photo ID ready so it can be copied for the clinic's records.

Person Responsible for Payment: ____________ Phone: ____________

Financial Responsibility: I understand that most insurance policies do not cover wellness chiropractic care for children. I understand that any treatment provided, that is not covered by health insurance, I am solely responsible for. This includes all fees and charges associated with this assessment and any future treatment provided by Carolinas Chiropractic and Spinal Rehab, regardless of insurance or extended health coverage.

Office Policies

Re-Exam Policy - If a patient has not been seen in our office for 90 days, they present with a new injury or area of complaint, or if insurance has changed they will be subject to a re-examination and a subsequent re-exam charge.

Cell Phone Policy - In an effort to keep a relaxing environment, please silence your cell phones and all electronic devices while in the office and please step outside to make or receive phone calls.

Cancellation Policy - We understand that there are emergencies and we will be sensitive to those issues; however we respect your time and ask that our time be respected as well. Please be advised that there is a $40 fee for all missed appointments without suffiecient notice. Please notify us by 2:00pm on the business day prior to your scheduled appointment to avoid a fee.

Children in the Office Policy - While we welcome children in our office, we do ask that you have an adult available to accompany them should they need to step out of the exam room or wait in the waiting room.

I, the undersigned, understand and agree to the above and, in order to be accepted as a patient in this office, agree to abide by these policies.

Signature: ____________ Date: ____________

Consent for Treatment

By signing below, I give my consent for examination and the performance of any tests or procedures needed. If patient is a minor, by signing I give consent for examination, tests and procedures for the above minor patient

Signature: ____________ Relationship to child:____________ Date: ____________

Doctor's Signature____________

Copyright 2008 © American Chiropractic Association | 1701 Clarendon Blvd. Arlington, VA 22209 | 703.276.8800