Pediatric Patient Questionnaire

Please PRINT clearly.

Today's Date:_____

PATIENT INFORMATION

Name: (Last, First, MI)_____ Preferred Name:_____

Address:_____ City:_____ State:_____ Zip:_____

Gender:_____ Date of Birth:_____ Age:_____ Height:_____ Weight:_____

# of Siblings: _____ Sibling(s) Names & Ages: _____

_____

Who can we thank for referring you or how did you hear about us? _____

Parents' Names: _____

Best Contact Phone: _____ Alternate Phone: _____

Email: _____

REASON(S) FOR SEEKING CARE

What is your reason for seeking care at Sozo Chiropractic? _____

_____

When did this begin? (if applicable): _____

Are there any major injuries and/or surgeries we should know about? _____

What is this affecting that is MOST important in your child's life? (List all that apply): _____

_____

Has your child seen a chiropractor before? _____ If so, how long ago? _____ Clinic/Doctor:_____

What is your reason for change? (If applicable): _____

What healthy goal, if you child were to complete or accomplish, would have the greatest impact on his/her life? _____

_____

_____

HEALTH CONCERNS

☐Anxiety/Depression ☐Fatigue/Sleep Issues ☐Constipation/Diarrhea ☐Asthma/Chronic Bronchitis ☐Nausea/Vomiting

☐Colic/Acid Reflux ☐Diabetes ☐Back/Neck Pain/Stiffness ☐Bed Wetting ☐Difficulty Gaining Weight ☐Overweight

☐Ear or Other Infections ☐Frequent Sickness ☐Headaches ☐ADD/ADHD ☐Learning Disorders ☐Detachment/Distant

☐Sinus Trouble/Allergies ☐Irritability/Nervous ☐Autism/Asperger's ☐Other_____

☐Other_____ ☐Other_____

Please explain any boxes checked above: _____

_____

_____

Is there anything else regarding your child's current condition you feel the doctor should know? _____

_____

_____

MEDICATIONS/VITAMINS

☐Anxiety/Depression ☐Migraine/Headache ☐Asthma ☐Acid Reflux ☐Pain Narcotics ☐ADD/ADHD ☐Antibiotics ☐Digestive

☐Other _____ ☐Other _____

☐Other _____ Explain any boxes checked above: _____

_____

☐Multi-Vitamins ☐Fish Oil/Omega-3 ☐Vitamin D3 ☐Probiotics ☐Other _____

Explain any boxes checked above: _____

_____

PRENATAL HISTORY

Location of Birth: ☐Home ☐Birthing Center ☐Hospital ☐Other: _____

Did any of the following happen during delivery: ☐C-Section ☐Doctor pulled or twisted baby ☐Anesthesia

☐Labor was induced ☐Forceps/Vacuum Extraction ☐Premature Delivery ☐Special Medical procedures/tests

Describe any of the above plus any additional complications experienced during delivery: _____

_____

During pregnancy, did you use any drugs, tobacco, alcohol, and/or medications? If yes, please list: _____

_____

Did you experience any illness while pregnant? ☐Yes ☐No If yes, explain: _____

Do you have any physical disabilities? ☐Yes ☐No If yes, explain: _____

Birth weight: _____ Birth Length: _____ APGAR Scores (if remembered): _____

Ultrasound used during pregnancy? ☐Yes ☐No Number of times (if applicable): _____ Did you breastfeed the baby? ☐Yes ☐No

If yes, how long? _____ Did you formula-feed the baby? ☐Yes ☐No If yes, how long? _____

At what age did you introduce: Solids: _____ Cow's Milk: _____

LIFESTYLE HABITS

Does your child exercise daily? ☐Yes ☐No How much? _____

Does your child drink soda? ☐Yes ☐No How much/often? _____

Does your child have a positive self-esteem or self-image? ☐Yes ☐No

Does your child watch more than an hour of TV per day? ☐Yes ☐No How much? _____

Does your child eat balanced meals? ☐Yes ☐No

Does your child experience prolonged sadness? ☐Yes ☐No Explain: _____

Does your child have difficulty sleeping? ☐Yes ☐No Explain: _____

Does your child play video games? ☐Yes ☐No How much? _____

THOUGHTS: Emotional Stresses & Challenges

The National Safety Council reports approximately 50% of children fell head first from a high place during their first year of life (bed, changing table, stairs, etc.). Was this the case for your child? ☐Yes ☐No Explain: _____

Has your child ever been hospitalized or had surgery? ☐Yes ☐No Explain: _____

Does your child have difficulty interacting with others? ☐Yes ☐No Explain: _____

Have you noticed that your child is nervous, twitches, shakes, or exhibits rocking behavior? ☐Yes ☐No Explain: _____

_____

Has your child been involved in any high impact/contact sports (soccer, football, martial arts, cheerleading, etc.) ☐Yes ☐No

Please list: _____

Are you aware of any food allergies or intolerance? ☐Yes ☐No Explain: _____

Has your child received all recommended vaccinations? ☐Yes ☐No Explain: _____

Please rate stress levels on a scale of 1-10 (10 being highest)

School: ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 Personal: ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

PERMISSION TO TREAT A MINOR

I, (Parent/Guardian) _____, give Sozo Chiropractic permission to examine, x-ray (if necessary), and care for _____.

Minor date of birth: _____

I have read the above information and certify it to be true and correct to the best of my knowledge and hereby authorize this office to provide me with chiropractic care, diagnostic testing, and/or therapeutic services, in accordance with this state's statutes. I choose to decline receipt of my clinical summary after every visit. (These summaries are often blank as a result of the nature and frequency of chiropractic care.

Parent or Guardian Signature: _____ Date: _____

Treating Doctor Signature: _____ Date: _____

Sozo Chiropractic LLC

Dr. Alyssa O'Connor

22386 Harrison St. Spring Hill, KS 66083

Notices of Privacy Practices

HIPPAA

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA) and updated laws, I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to: *Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly. *Conduct normal healthcare operations such as quality assessments and physician certifications. I have been informed by you and your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I many contact this organization at any time to obtain a current copy of the Notice of Privacy Practices. I understand that I many request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restriction, but if you do agree then you are bound to abide by such restrictions. I further authorize disclosure of all or any part of my patients record to any person or corporation which is or may be liable under a contract to the clinic or to the patient or to ta family member or employer of the patient for all or part of the clinics charge including, not limited to, hospital or medical service companies, insurance companies, workers compensation carriers, welfare funds or the patient's employer. I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this account.

Consent Regarding: Chiropractic adjustments, modalities, and therapeutic procedures
I have been advised that chiropractic care, like all forms of health care, hold certain risks. While the risks are most often very minimal, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible strong-which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments.

Treatment objectives, as well as the risks associated with chiropractic adjustments and all other procedures provided at Sozo Chiropractic have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby, consent to treatment by any means, methods, and or techniques the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

_____ _____
Patient Name (print) witness initials

_____ _____/_____/_____
Patient or Guardian Signature Date

Clinıcal Summary Report (CCR) regarding HER
I understand that a clinical summary report is created after each visit for the purpose of HER and is available for my review. At this time, I am asking Sozo Chiropractic LLC to save these electronically for me and not print them out after each visit. I understand that, upon request, these reports are available to be printed or emailed to me for review.

Assignment of Benefits
I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that this Chiropractic Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this Chiropractic Office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are changed directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

Media Release
I understand and give permission to Sozo Chiropractic LLC, to share my chiropractic story. I give my permission for the following information to be shared: (first name, age, picture, video, treatment results) by the following ways: (in office, social media, website).

Print Patient Name: _____

Authorized Signature: _____

Relationship to patient (if not self): _____

Date: _____

Report of Finances
(Fee for services)

The following are services that our office will be billing to insurance companies. The items/services listed below may or may not be covered when preformed in this office by our providers. Patient understands they are seeking treatment for correction of vertebral subluxation.

Initial Consultation Fee includes the following: *Examination *Neurological scans *Report of findings	Fee $125

Patient or Guardian Signature: _____ Date:_____