Parent/Child Health Questionnaire

Name of Parent_____

Address _____

_____

City/State/Zip _____

Phone # Work _____(Hours___ to ___)

Home _____

Name of Child_____

Address (if different from parent)

_____

_____

Phone #_____ Sex M F

Date of Birth _____Age _____

Who is responsible for your child's bill? ☐ You ☐ Spouse ☐ Auto Insurance
☐ Personal Health Insurance_____

During pregnancy, were you on medication? Did you smoke or consume any alcoholic beverages?

_____

Was there back pain?_____

_____

Approximately how long was labor?_____

_____

Were you physically ill? (Colds, flu, allergies, German measles, anything like that) _____

If so, what? _____

Regarding Labor:

Was it chemically induced?	☐ Yes	☐ No
Doctor assisted?	☐ Yes	☐ No
Was C-Section performed?	☐ Yes	☐ No
Were forceps used?	☐ Yes	☐ No
Did doctor have hands on the infant?	☐ Yes	☐ No
Were you lying down?	☐ Yes	☐ No
Was family member present?	☐ Yes	☐ No

If yes, who? _____

(95% of all infants were born with hands on or forceps)

Was the baby premature? ☐ Yes ☐ No

If so, what was his/her age and weight? _____

Did your child suffer any health problems, such as:

Headaches	☐ Yes	☐ No	Meningitis	☐ Yes	☐ No
Allergies	☐ Yes	☐ No	Diarrhea	☐ Yes	☐ No
Ear Problems	☐ Yes	☐ No	Constipation	☐ Yes	☐ No
Sleeping Disorders	☐ Yes	☐ No	Colic	☐ Yes	☐ No
Breathing Problems	☐ Yes	☐ No	Rashes	☐ Yes	☐ No
Fatigue	☐ Yes	☐ No	Milk or Lactose Intolerance	☐ Yes	☐ No
Irritability	☐ Yes	☐ No	Bed Wetting	☐ Yes	☐ No
Hyperactivity	☐ Yes	☐ No	Digestive Problems	☐ Yes	☐ No
Frequent Colds	☐ Yes	☐ No	Other: _____		
Flu	☐ Yes	☐ No	_____		
Bloody Noses	☐ Yes	☐ No	_____		

Regarding your child today:

Is your child accident prone: ☐ Yes ☐ No

Has the child had any falls down steps? ☐ Yes ☐ No

Has your child ever fallen from heights over 2 feet? ☐ Yes ☐ No

Has your child ever been involved in a motor vehicle accident? ☐ Yes ☐ No

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

Does your child suffer from:

Allergies	☐ Yes	☐ No
Asthma	☐ Yes	☐ No
Headaches	☐ Yes	☐ No

Has your child ever had any broken bones or sprain injuries? ☐ Yes ☐ No

Is your child on any medication? ☐ Yes ☐ No

Has your child had a scoliosis examination by an approved scoliosis determination procedures clinic? ☐ Yes ☐ No

Is your child hyperactive?	☐ Yes	☐ No
Have learning disorders?	☐ Yes	☐ No
Sleeping difficulty?	☐ Yes	☐ No
Poor posture?	☐ Yes	☐ No

Does your child have any problem associating with friends? ☐ Yes ☐ No

Is your child nervous, or has anyone suggested that your child was nervous? ☐ Yes ☐ No

Does your child show any signs of nervousness, twitching or excessive talking to themselves? ☐ Yes ☐ No

If you could improve one aspect of your child's health or behavior, what would it be?_____

_____

_____

DO NOT WRITE BELOW THIS LINE

CHIROPRACTIC ANALYSIS:

DIAGNOSIS:

Patient Accepted ☐ Yes ☐ No ☐ Referred

_____
Doctor's Signature

Naturally CHIROPRACTIC, P.C.

AUTHORIZATION FOR RELEASE OF HEALTH SERVICE / TREATMENT INFORMATION

This authorization, or photocopy / facsimile thereof, will authorize you to furnish Naturally Chiropractic, P.C. [*Brian Burford, D.C. / Lori Milanovich, D.C. / Christian Stack, D.C.*], with all information you may have regarding my condition while under your observation or treatment, including history obtained, examination findings, diagnosis, and prognosis.

This authorization also serves to authorize Naturally Chiropractic, P.C. [*Brian Burford, D.C. / Lori Milanovich, D.C. / Christian Stack, D.C.*], to release all information regarding my condition while under his / her treatment.

PATIENT'S NAME: _____ DATE: _____

PLEASE PRINT

SIGNATURE OF CONSENT: _____

SIGNATURE OF GUARDIAN: _____

PLEASE USE ONLY IF PATIENT IS UNDER AGE OF 18

Naturally CHIROPRACTIC, P.C.

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

Our commitment here at Naturally Chiropractic, P.C. is to serve our patients with professionalism and caring. At all times, we want to be sure to protect the privacy and security of all protected health information. During the course of serving your interests, it may be necessary to share information with other health care providers or business associates. The following are examples of when information may need to be shared:

- During treatment, we may find it necessary to acquire an x-ray, imaging study, or associated radiological report.
- For payment purposes, we may use the services of a billing service.
- During health care operations, we may need a second opinion.

We here at Naturally Chiropractic, P.C. are committed to abiding by all Federal, State and Local laws and regulations regarding privacy practices. If any uses or disclosures, other than the ones listed above, are needed, the information will only be released with the written authorization of the individual in question. This written authorization may be revoked at any time by the individual, as provided for by law.

_____ I have read and understand the above Notice of Privacy Practices.
Initial

_____ I am aware that there is a copy of the Private Practices report available in the waiting room for my viewing.
Initial

I authorize Naturally Chiropractic, P.C. to contact me or leave a message at the following numbers:

HOME:	Y	N	(___) _____	*OK TO LEAVE MESSAGE?*	Y	N
WORK:	Y	N	(___) _____	*OK TO LEAVE MESSAGE?*	Y	N
CELL:	Y	N	(___) _____	*OK TO LEAVE MESSAGE?*	Y	N
E-MAIL:	Y	N	_____	*OK TO LEAVE MESSAGE?*	Y	N

Patient's Name _____ **Date** _____
Please Print

Signature of Consent _____
Please Sign

Signature of Guardian _____
Please Use Only If Patient Is Under Age of 18