



PEDIATRIC HEALTH QUESTIONNAIRE (AGES 16 AND UNDER)

First Name: _____ Last Name: _____ Date: _____
Date of Birth: _____ Please Select: Male Female
Name of Parents: _____
Address: _____
Residence and mailing City State Zip Code
Best Contact Number:(_____) _____ Email Address: _____
Who may we thank for referring you to our office: _____

HEALTH HISTORY

Reason for seeking care in our office? _____

Any other concerns? _____

When was your child's last fall or trauma? _____ Was any care given? Y / N

Was he/she checked by a chiropractor? Y / N

Has your child fallen from heights of over 2 ft or had any falls down stairs? Y / N If yes, please describe: _____

Has your child ever been seen on an emergency basis? Y / N If yes, please describe: _____

Please list all past and present athletic activities your child has participated in: _____

Has your child ever been involved in an automobile accident? Y / N If yes, please describe: _____

Are you concerned about any developmental delays? Y / N If yes, please explain: _____

List any current medications or supplements: _____

On a scale of 0-10, please describe your child's stress level (0=None, 10=Extreme): _____

PLEASE CHECK ANY OF THE FOLLOWING CONDITIONS THAT YOUR CHILD HAS SUFFERED FROM IN THE LAST YEAR

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Colic | <input type="checkbox"/> Growing pains | <input type="checkbox"/> Reflux |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Headaches | <input type="checkbox"/> Rubella |
| <input type="checkbox"/> ADHD/ADD | <input type="checkbox"/> Digestive problems | <input type="checkbox"/> Irritability | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Back pain | <input type="checkbox"/> Major Dental work | <input type="checkbox"/> Lyme disease | <input type="checkbox"/> Scoliosis |
| <input type="checkbox"/> Bedwetting | <input type="checkbox"/> Ear infections | <input type="checkbox"/> Neck pain | <input type="checkbox"/> Sleeping disorders |
| <input type="checkbox"/> Breathing problems | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Poor posture | <input type="checkbox"/> Other |
| <input type="checkbox"/> Colds | <input type="checkbox"/> Fevers | <input type="checkbox"/> Rashes | |



HIPAA Form

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to define situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment, or practice operations will be made only after obtaining your consent. You may request restrictions on your disclosures. You may inspect and receive copies of your records within 30 days of request. You may request to view charges to your records. In the future, we may contact you for appointment reminders, announcements and to inform you about our practice and its staff.

I understand that, under the Health Insurance Portability and Accountability Act of 1996 [HIPAA], 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 with multiple healthcare providers who may be involved in that treatment directly or indirectly, obtain payment from third party payers, and conduct normal healthcare operations such as quality assessments and physician's certificates. I have read and understand your Notice of Privacy Practices. I also understand that I can request in writing that you restrict how my personal information is used and disclosed.

Print Name

Date

Signature

Consent for Minor Patient:

I, _____ being the parent or legal guardian of
_____ have read and fully understand the above HIPAA Form.

Print Name

Date

Signature