JOHNSON CITY FAMILY CHIROPRACTIC

89 Harry L. Drive, Johnson City, NY 13790
Phone: 607-798-0356 Fax: 607-798-0164
www.jcfamilychiropractic.com

Pediatric Health Questionnaire *Please e-mail to jcfchiro@outlook.com or print it and bring it with you to your first appointment.

Name: _____ Date of Birth: ___/___/___ ☐ Male ☐ Female

Address: _____ City, State, ZIP: _____

Mother: _____ Cell Phone: _____

Father: _____ Cell Phone: _____

Home Phone: _____ Parents Email: _____

Number of Siblings: _____ Name(s) of Siblings: _____

Pediatrician/ Family MD: _____ Office Location: _____

Who is responsible for this account? ☐ Mother SS #: _____ ☐ Father SS #: _____

Many patients are referred to our office by family or friends. Who can we thank for referring you? _____

Welcome to our office. We are honored that you have chosen our office to serve your family. Please know that we will care for your child with the greatest respect and care for them as if they are our own.

Why did you decided to have your child evaluated at our office?

☐ He/ She is continuing ongoing care from another chiropractor.
☐ I recently had my spine and nervous system checked and understand the value in getting my baby checked.
☐ I have concerns about his/her health and I'm looking for answers.
☐ He/ She has specific condition and I've learned that chiropractic may be able to help.
☐ I'm interested in improving my child's overall health and wellness.
☐ Other: _____

Wellness Profile: Chiropractic care affects more then just muscles, joints and how we feel. Chiropractic helps our bodies function at a higher level which increases our overall health and wellness. Please share with us what health goals you hope to achieve for your child.

☐ Better Sleep ☐ Freedom from Discomfort ☐ Improved Breastfeeding ☐ Easier Breathing ☐ More Energy

☐ Improved Nutrition & Diet ☐ Improved Coordination ☐ Eliminate Medications ☐ Stronger Immune System

☐ Improved Bowel Function ☐ Improved Posture ☐ Better Sport Performance ☐ Better Concentration

☐ Improve Overall Health ☐ Enhanced Emotional Well-Being ☐ Other: _____

The majority of children have experienced hundreds of impacts that could cause vertebrae to become misaligned or subluxated. What we need to do now is discover several of the traumas your child has suffered.

What was your child's birth like? ☐ Easy ☐ Stressful ☐ Complicated ☐ Surgical

How long was the entire labor? _____ How long did you actually push for? _____
Were you induced? ☐ Yes ☐ No Nerve block? ☐ Yes ☐ No C-Section? ☐ Yes ☐ No
Was there any pulling on the head? ☐ Yes ☐ No ☐ Mid-wife/OBGYN? ☐ Forceps or Vacuum extraction?

Any other birth trauma? _____

Patient Name: File#

Science has shown that 47% of all children fall on their heads by the age of 1 and have at least 200 major falls by the age of 5.

When was your child's most recent fall? _____
Any care given? ☐ Yes ☐ No Chiropractic adjustment? ☐ Yes ☐ No

What sports or recreational activities does your child do? _____
When was your child's most recent stress, strain, or injury while doing these activities? _____
Any care given? ☐ Yes ☐ No Chiropractic adjustment? ☐ Yes ☐ No

Poor posture leads to poor health and early death. How would you rate your child's posture? (1 = poor; 10 = excellent)
☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

Stress causes your spine to misalign and accelerates spinal damage. Rate your child's stress level. (1 = none; 10 =intense)
☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

Prescription medications can cause various side effects, hide the severity of health problems, and hinder the body's ability to heal. What medications is your child currently taking? _____

_____

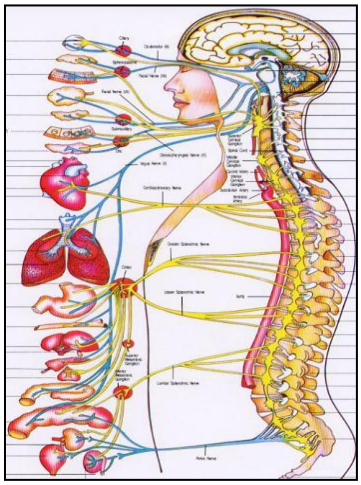
Please list vitamins/supplements your child takes:_____

Please list any surgeries your child has had. _____

Improper sleeping positions can cause spinal misalignment. What sleeping position does your child sleep in?
☐ Back ☐ Stomach ☐ Right side ☐ Left side

Subluxation (Misalignment) of the spine will lead to health problems in your child's body.
Please CIRCLE or list any health challenge your child is experiencing.

Allergies
Ear Infection/ Tubes
Behavioral Challenges
Asthma
Colic I
Digestive (Constipation/IBS)
Bed Wetting



Headaches/Migraines
Neck Pain L / R
Temper Tantrums
Mid Back Pain L / R
Low Back Pain L / R
Leg Pain L / R

Anxiety/ Depression
Auto-Immune Disease

Allergies (please list):
_____
_____
_____

The information in this Health Questionnaire is true and accurate to the best of my knowledge.

_____

Signature (Patient or parent/guardian) Date

Patient Name: File#

Informed Consent for Chiropractic Care:

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both of us to be working toward the same objective. It is important that each patient understand both the objective(s) and the method(s) that will be used to attain this objective. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition and the recommended care to be provided so that you make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks, and alternatives.

Chiropractic is a science, philosophy and art that concerns itself with the relationship between the spinal structure and the health of the nervous system. As chiropractors we understand that health is a state of optimal physical, mental, and social wellbeing, not merely the absence of disease or infirmity.

One disturbance to the nervous system is called a vertebral subluxation. This occurs when one or more of the 24 vertebra in the spinal column become misaligned and/or do not move properly. This causes an unhealthy change to nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by a chiropractic adjustment. An adjustment is the specific application of force to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments to the spine. Adjustments are done by hand or with an instrument where the doctor will put pressure on the specific segment(s) of the spine to adjust the vertebrae into a better position.

If at the beginning or during the course of care we encounter a non-chiropractic or unusual findings, we will advise you of those findings and recommend some further testing or refer you out to another health care provider.

Chiropractic care has been proven to be very safe and effective. It is not unusual however, to be sore after your first few corrective adjustments. Although rare it is possible to suffer from other side effects, i.e. muscle spasms, stiffness, rib fracture, headache, dizziness and stroke.

All questions regarding the doctor's objective to my care in this office has been answered to my complete satisfaction. The benefits, risks and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

Consent to evaluate and adjust a minor child:

I, _____, being the parent or legal guardian of _____ have read and fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care.

Signature (or Parent/Guardian) Date

Notice of Privacy Practices:

This notice describes how health information about you is stored, may be used, and or disclosed.

How We Store Your Information: Patient information is stored here in the office on a server with no outside access. X-ray images are also stored on the server and hard copies of your file and x-rays are stored here in our office. All storage is secure and meets or exceeds HIPPA requirements and regulations.

What We Do Not Do With Your Information: Information about your financial situation, medical conditions, and care that you provide to us in writing, via email, on the phone (including information left on voice mails), contained in or attached to applications, or directly or indirectly given to us, is held in strictest confidence. We do not give out, exchange, barter, rent, sell, lend, or disseminate any information about our patients to anyone who receives our services. Know that any and all patient information is considered confidential, is restricted by law, or has been specifically restricted by a patient/client in a signed HIPAA consent form.

How We Do Use Your Information: Information is only used as is reasonably necessary to process your care, billing to an insurance company or to provide you with health or services which may require communication between Johnson City Family Insurance and health care providers, insurance companies, and other providers necessary to: verify your medical information is accurate; determine the type of medical supplies or any health care services you need including, but not limited to; obtaining or purchasing any type of medical supplies, devices, medications and insurance.

No Patients information and no identifying information (photo, address, phone number, contact information, last name or uniquely identifiable name) will ever be used without patient's express written advance permission.

Signature (Patient or parent/guardian) Date

Patient Name: File#

Photo Waiver:
This is to acknowledge my approval to allow Johnson City Family Chiropractic to take my picture for the use of patient file identification and patient evaluation only. **This photo will never be used for any purpose other than patient identification and patient evaluation, nor will this photo be shared with any outside source.**

Signature (Patient or parent/guardian) Date

Release of Medical Records:
I give my permission for Johnson City Family Chiropractic to request medical information from other medical facilities that may help the doctor to accurately assess and treat my current condition.

Signature (Patient or parent/guardian) Date

Financially Responsibility:
I understand I am financially responsible for any charges incurred at this office. I understand this office will require payment from me for these services. Any payment due beyond 30 days is subject to late fees, interest at 1.5% per month and collection agency fees. I agree to pay all collection costs associated with collecting said debt, including, but not limited to attorney fees of 25% (twenty-five percent), together with the costs and disbursements of the action.

I have read this statement and understand my obligations for payment for care.

Signature (Patient or parent/guardian) Date