Pediatric Patient Questionnaire

Confidential Patient Information

Child's Name: | Parent/Guardian Name(s):

Street Address: | City, State, Postal Code:

Cell Phone: | Other Phone: | Child's Sex:

Email: | Child's SSN: | Birthdate: | Age:

How did you hear about us? | Height: | Weight:

Who is your primary care physician?

Is your child receiving care from any other health professionals? ○ Yes ○ No
– If yes, please name them and their specialty:

Please list any drugs/medications/vitamins/herbs or other that your child is taking:

Current Health Conditions

What health condition(s) bring your child to be evaluated by a chiropractor?

When did the condition first begin? | How did the problem start? ○ Suddenly ○ Gradually ○ Post-Injury

Has your child ever received care for this condition? ○ Yes ○ No
– If yes, please explain:

Is this condition: ○ Getting worse ○ Improving ○ Intermittent ○ Constant ○ Unsure

What makes the problem better? | What makes the problem worse?

Health Goals for Your Child

What are your top three health goals for your child?

1. _____
2. _____
3. _____

What would you like to gain?

○ Resolve existing condition
○ Overall wellness
○ Both

Has your child ever visited a chiropractor? ○ Yes ○ No – If yes, what is their name:

– What is their specialty: ○ Pain Relief ○ Physical Therapy & Rehab ○ Nutrition ○ Subluxation-based ○ Other:

Pregnancy & Fertility History

Please tell us about your pregnancy:

Any fertility issues? ○ Yes ○ No If yes, please explain: _____

Did mother smoke? ○ Yes ○ No If yes, how often? _____

Did mother drink? ○ Yes ○ No If yes, how often? _____

Did mother exercise? ○ Yes ○ No If yes, please explain: _____

Was mother ill? ○ Yes ○ No If yes, please explain: _____

Any ultrasounds? ○ Yes ○ No If yes, please explain: _____

Please explain any noticable episodes of mental or physical stress during your pregnancy:

Please explain any other concerns or notable remarks about your child's conception or pregnancy:

Labor & Delivery History

Child's birth was: ○ Natural vaginal birth ○ Scheduled C-section ○ Emergency C-section – At how many weeks was your child born?

Where was your child born? – Who delivered your baby?

Please indicate any applicable interventions or complications:
○ Breech ○ Induction ○ Pain meds ○ Epidural ○ Episiotomy ○ Vacuum extraction ○ Forceps ○ Other:

Please describe any other concerns or notable remarks about your child's labor and/or delivery:

Child's birth weight: Child's birth height: APGAR score at birth: APGAR score after 5 min.:

Growth & Development History

Is/was your child breastfed? ○ Yes ○ No – If yes, how long? Difficulty with breastfeeding? ○ Yes ○ No

Did they ever use formula? ○ Yes ○ No – If yes, at what age? – If yes, what type?

Did/does your child suffer from colic, reflux, or constipation as an infant? ○ Yes ○ No
– If yes, please explain:

Did/does your child frequently arch their neck/back, feel stiff, or bang their head? ○ Yes ○ No
– If yes, please explain:

At what age did the child: Respond to sound:_____ Follow an object:_____ Hold their head up:_____ Vocalize:_____
Teethe:_____ Sit alone:_____ Crawl:_____ Walk:_____ Begin cow's milk:_____ Begin solid foods:_____

Please list any food intolerance or allergies, and when they began:

Please list your child's hospitalization and surgical history (including the year):

Please list any major injuries, accidents, falls and/or fractures your child has sustained in his/her lifetime (including the year):

Have you chosen to vaccinate your child? ○ No ○ Yes, on a delayed or selective schedule ○ Yes, on schedule
– If yes, please list any vaccine reactions:

Has your child received any antibiotics? ○ Yes ○ No
– If yes, how many times and list reason:

Night terrors or difficulty sleeping? ○ Yes ○ No – If yes, please explain:

Behavioral, social or emotional issues? ○ Yes ○ No – If yes, please explain:

How many hours per day does your child typically spend watching TV, computer, tablet or phone?

How would you describe your child's diet? ○ Mostly whole, organic foods ○ Pretty average ○ High amount of processed foods

Acknowledgement & Consent

Parent/Guardian Signature: _____ Date: _____

Dr. Kimberly Guthrie & Dr. Jessica Hudson | Body in Balance Wellness Center – *Balancing you from the inside out.*
7360 SW Hunziker st. Ste 203 Tigard, OR 97223 | 503-675-8747 | www.bbwellnesscenter.com

AUTHORIZATION FOR CARE

I hereby authorize the Doctor to work with my condition through the use of adjustments to my spine, as he or she deems appropriate. I clearly understand and agree that all services rendered me are charged directly to me and that I am responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand that if I suspend or terminate my care, any fees for professional services rendered me will become immediately due and payable.

I hereby authorize assignment of my insurance rights and benefits (if applicable) directly to the provider for services rendered. I understand and agree that health and accident insurance policies are on arrangement between an insurance carrier and myself. I understand that the Doctor's office will prepare any necessary reports and forms to assist me in collecting from the insurance company and that any amount authorized to be paid directly to the Doctor's office will be credited to my account on receipt.

Ownership of X-ray Films: It is understood and agreed that the payments to the Doctor for X-rays is for examination of X-rays only. The X-ray negative will remain the property of the office. They are kept on file where they may be seen at any time while I am a patient at this office.

SIGNATURE:	DATE:
SIGNATURE OF GUARDIAN OR SPOUSE AUTHORIZING CARE:	DATE:

WHO SHOULD RECEIVE BILLS FOR PAYMENT ON YOUR ACCOUNT?

☐PATIENT ☐SPOUSE ☐PARENT ☐WORKERS COMP ☐AUTO INSURANCE

TERMS OF ACCEPTANCE

When a patient seeks chiropractic care we accept such a patient for care, it is essential for both to be working towards the same objective. Chiropractic has only one goal. It is only when the patient understands both the objective and the method that they will be able to attain it. This will prevent any confusion or disappointment.

An **adjustment** is the specific adjustments to the spine.

Health is a state of optimal physical, mental and social wellbeing, not merely the absence of disease.

Vertebral Subluxation is a misalignment of one or more of the joints of the body. This can cause pain or alteration of nerve function and interference of the transmission of nerve impulses, lessening the body's innate ability to maintain maximum health.

We do not offer to diagnose or treat any disease or condition other then vertebral subluxation. However, if during the course of a chiropractic spinal evaluation, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area. Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxation.

I have read and fully understand the above statement. Any questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfactions. I therefore accept chiropractic care on this basis.

SIGNATURE:	DATE:
WITNESS SIGNATURE:	DATE:

NOTICE OF PRIVACY POLICY

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to defined 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 with a request.
- You may request to view changes 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 & Accountability Act of 1996 (HIPPA)*, 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.
- Conduct normal healthcare operation such as quality assessments and physician's certifications.

I have read and understand your *Notice of Privacy Practices*. A more complete description can be requested. I also understand that I can request, in writing, that you restrict how my personal information is used and or disclosed.

PATIENT NAME (PLEASE PRINT):	RELATIONSHIP TO PATIENT:
SIGNATURE:	DATE:

Body in Balance Wellness Center

Dr. Kimberly Guthrie and Dr. Jessica Hudson
Chiropractic Physicians
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Tigard, OR. 97223
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OFFICE & FINANCIAL POLICIES

- Payment is expected at the time of service. We accept cash, check, Visa, Mastercard, Discover and Care Credit.
- You are responsible for timely payment on your account. Unpaid balances over 60 days may be charged 1.5% interest per month (18% annual) and/or subject to collection activity.
- Maximum allowable outstanding balance is $200.00 unless other arrangements have been made. You may be ineligible to receive further services until your balance is paid down.
- All supplements/vitamins, lab work, supports and other supplies must be paid for at the time they are received unless prior arrangements have been made.
- If you are late for your re-exam appointment, this may result in additional waiting time, and your scan may need to be rescheduled.
- If you have not had an adjustment in three months, you must have an exam prior to being adjusted.
- If you choose to discontinue care, you are required to have an exam before being released from care. If you choose to return, you must have an exam before your next adjustment.

Motor Vehicle Accident, Personal Injury and Worker's Compensation Claims:

- Cases will be billed directly to the insurance company, providing the appropriate paperwork has been filled out and a claim is filed. **If your claim is denied or reimbursement/compensation does not cover fees incurred, you are responsible for prompt payment of your account balance.**
- We do not do third party billings to other insurance companies for motor vehicle accident and personal injury cases.
- If you choose not to file a claim with your insurance company, or are uninsured, your account will be treated as a cash account and all fees will be due at the time of service.
- Lab work, supports and other supplies may not be covered by your insurance company. If your insurance company does not pay such items, then you are responsible for your bill.
- If you are late for your appointment, this may result in additional waiting time, an adjustment only, or your appointment may need to be rescheduled.
- Missed appointments may be subject to a $75.00 cancellation fee if we do not receive your cancellation at least 4 hours prior to your scheduled appointment. You are responsible for this fee and it must be paid in full prior to your next appointment.

By signing below, you have read, understand and agree to the above office and financial policies.

_____ _____

Patient Signature or Guardian Signature Date