

PEDIATRIC QUESTIONNAIRE

Name: (Last, First MI) _____

Today's Date: _____

PEDIATRIC REVIEW OF SYSTEMS

Pediatric:

- ☐ ADHD
- ☐ Allergies/Asthma
- ☐ Autism
- ☐ Back/Neck Pain
- ☐ Bed Wetting
- ☐ Behavioral issues
- ☐ Chronic Earaches
- ☐ Colic
- ☐ Constipation
- ☐ Growing Pains
- ☐ Nightmares
- ☐ Reflux
- ☐ None in this Category

Childhood Diseases:

- ☐ Chicken Pox: Age _____
- ☐ Measles: Age _____
- ☐ Meningitis: Age _____
- ☐ Mumps: Age _____
- ☐ Rubella: Age _____
- ☐ Tuberculosis: Age _____
- ☐ Whooping Cough: Age _____
- ☐ Other: _____ Age _____
- ☐ None in this Category

Has your child been vaccinated?

☐ No ☐ Yes

(Any Adverse Reactions? -- Describe:) _____

INFANTS AND NEWBORNS

Prenatal History:

Location of Birth: ☐ Home ☐ Birthing Center ☐ Hospital

Birth Weight: _____ Birth Length: _____ Full Term? ☐ No ☐ Yes (Describe) _____

Complications during pregnancy? ☐ No ☐ Yes (Describe) _____

Medications during pregnancy or delivery? ☐ No ☐ Yes (List) _____

Cigarette / Alcohol / Drugs during pregnancy? ☐ No ☐ Yes (List) _____

Birth Interventions? ☐ No ☐ Yes ☐ Forceps ☐ Vacuum ☐ Caesarian ☐ Other: _____

Complications during delivery? ☐ No ☐ Yes (Describe) _____

Feeding History:

Breast fed? ☐ No ☐ Yes (How Long?) _____ Formula fed? ☐ No ☐ Yes (How Long?) _____ (Type?) _____

Introduced to cereal at _____ months old. Solids at _____ months old. Cow's milk at _____ months old.

Food / Juice allergies or intolerances? ☐ No ☐ Yes (Describe) _____

Developmental History:

Sleep (Hours per Night?) _____ Problems Sleeping? (Describe) _____

CONSENT FOR TREATMENT OF A MINOR

I hereby authorize: _____ (Doctor's Name) and whomever he or she may designate as assistants to administer examinations and chiropractic care as deemed necessary to: _____ (Minor Patient's Name)

Printed Name of Parent or Guardian

Signature of Parent or Guardian

Date

Witness

Date

Patient No: _____

INTRODUCTION PATIENT CASE HISTORY

Today's Date: _____

PATIENT INFORMATION

Name: (Last, First MI) _____ Preferred Name: _____
Address: _____ City: _____ State: _____ Zip: _____
Home: _____ Mobile: _____ Mobile Carrier: _____ Work: _____
Email: _____ Gender: M / F Marital Status: Married / Other / Single
Social Security #: _____ Date of Birth: _____
Student Status: Full Student / Part Student / Non-Student ☐ Employed Employer: _____
*Referred By: _____

Ethnicity: Hispanic or Latino / Other Preferred Language: _____
Race: Asian / African Am. / Am. Indian or Alaskan Native / Other / Native Hawaii or Pacific Island / White Smoking Status: Every Day / Some Days / Former / Never

EMERGENCY CONTACT INFORMATION

Full Name: _____ Primary Care Physician: _____
Home: _____ Mobile: _____ Doctor's Phone: _____
Relationship: Child / Parent / Spouse / Other: _____

FINANCIAL INFORMATION

☐ Insurance ☐ Worker's Comp ☐ Self-Pay (Cash) ☐ Personal Injury/Auto ☐ Other (please explain): _____

PRIMARY INSURANCE

Name: _____
Relation to Insured: Self / Spouse / Parent / Child / Other
Other than Self:
Insured's Name: _____ Gender: M / F
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Date of Birth: _____

SECONDARY INSURANCE

Name: _____
Relation to Insured: Self / Spouse / Parent / Child / Other
Other than Self:
Insured's Name: _____ Gender: M / F
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Date of Birth: _____

Who is responsible for payment? Self / Other - (Relationship) _____

Other than Self:

Full Name: _____ Phone: _____

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

It is Usual and Customary to Pay for Services as Rendered Unless Otherwise Arranged

Patient No: _____

PATIENT CASE HISTORY



HISTORY OF CURRENT CONDITION

Describe Major Complaint: _____

Began When? ____/____/____ **Describe how this began:** _____

Grade Intensity/Severity of Complaint: None / Mild / Moderate / Severe / Very Severe

Quality of the complaint/pain: Sharp / Stabbing / Burning / Achy / Dull / Stiff & Sore / Other: _____

How frequent is the complaint present? Off & On / Constant

Does this complaint radiate/shoot to any areas of your body? No / Yes (Describe) _____

Head - Base of Skull / Forehead / Sides-Temple R / L / Both

Leg - Hip / Thigh-Knee / Calf / Foot-Toes R / L / Both

Arm - Across Shoulder / Elbow / Hand-Fingers R / L / Both

Other Area: _____

Does anything make the complaint better? Ice / Heat / Rest / Movement / Stretching / OTC / Other: _____

Does anything make the complaint worse? Sit / Stand / Walk / Lying / Sleep / Overuse / Other: _____

Which daily activities are being affected by this condition? (Describe) _____

For this CURRENT condition, have you:

• Received any other treatment? None / DC / MD / PT / Massage / ER / Other: _____ **Where?** _____

• Had any previous Surgery or Interventions in this area? (Describe) _____

• Taken any Medications? OTC / Prescriptions _____

• Had any diagnostic testing? X-rays / MRI / CT / Other: _____ **When and Where?** _____

Describe any Secondary Complaints: _____

HEALTH HISTORY -- (PLEASE USE THE REVERSE SIDE OF THIS PAGE IF ADDITIONAL SPACE IS NEEDED)



Medications:

Allergies to Medications: NONE (List) _____

Current Medications: NONE

(Already have a list? We can make a copy.)



Past Health History: (Please list any past...)

Surgeries – Date, Type, and Reason: NONE

Major Injuries/Traumas: NONE

Major Hospitalizations: NONE



Family Health History: (Please mark N/A if not relevant.)

List relevant major health problems of immediate relatives:

Deaths in immediate family: (Cause and at what Age?)



Social and Occupational History:

Level of Education Completed: _____

High School / Some College / College Grad. / Post Grad. / Other

Lifestyle: (Hobbies, Rec. Activities, Exercise, Diet, Work, Vitamins)

Habits:

Cigarettes – (#/day) _____

Alcohol – (amount/day) _____

Coffee/Tea – (cups/day) _____

Rec. Drugs (List) _____

Patient No: _____

Are you currently experiencing any of these symptoms? (Check all the apply)
Many of the following conditions respond to Chiropractic and Acupuncture treatment.

General: (constitutional)

- ☐ Recent Weight Change
- ☐ Fever
- ☐ Fatigue
- ☐ None in this Category

Musculoskeletal:

- ☐ Low Back Pain
- ☐ Mid Back Pain
- ☐ Neck Pain
- ☐ Arm Problems _____
- ☐ Leg Problems _____
- ☐ Painful Joints
- ☐ Stiff/Swollen Joints
- ☐ Sore/Weak Muscles or Joints
- ☐ Muscle Spasms/Cramps
- ☐ Broken Bones _____
- ☐ Other: _____
- ☐ None in this Category

Neurological:

- ☐ Numbness or tingling sensations
- ☐ Loss of Feeling
- ☐ Dizziness or light headed
- ☐ Frequent or Recurrent Headaches
- ☐ Convulsions or seizures
- ☐ Tremors
- ☐ Stroke
- ☐ Have you ever had a head injury?
- ☐ Ever been in an auto accident?
- ☐ Other: _____
- ☐ None in this Category

Mind/Stress:

- ☐ Nervousness
- ☐ Depression
- ☐ Sleep Problems
- ☐ Memory Loss or Confusion
- ☐ Other: _____
- ☐ None in this Category

Genitourinary:

- ☐ Sexual Difficulty
- ☐ Kidney Stones
- ☐ Burning/Painful Urination
- ☐ Change in force/strain w Urination
- ☐ Frequent Urination
- ☐ Blood in Urine
- ☐ Incontinence or Bed Wetting
- ☐ Other: _____
- ☐ None in this Category

Gastrointestinal:

- ☐ Loss of Appetite
- ☐ Blood in Stool
- ☐ Change in Bowel Movements
- ☐ Painful Bowel Movements
- ☐ Nausea or Vomiting
- ☐ Abdominal Pain
- ☐ Frequent Diarrhea
- ☐ Constipation
- ☐ Other: _____
- ☐ None in this Category

Cardiovascular & Heart:

- ☐ Chest Pains
- ☐ Rapid or Heartbeat changes
- ☐ Blood Pressure Problems
- ☐ Swelling of Hands, Ankles, or Feet
- ☐ Heart Problems
- ☐ Other: _____
- ☐ None in this Category

Respiratory:

- ☐ Difficulty Breathing
- ☐ Persistent Cough
- ☐ Coughing Blood
- ☐ Asthma or Wheezing
- ☐ Lung Problems
- ☐ Other: _____
- ☐ None in this Category

Eyes and Vision:

- ☐ Wear contacts/glasses
- ☐ Blurred or double vision
- ☐ Glaucoma
- ☐ Eye disease or injury
- ☐ Other: _____
- ☐ None in this Category

Ears, Nose and Throat:

- ☐ Bleeding gums / mouth sores
- ☐ Bad Breath or bad taste
- ☐ Dental Problems
- ☐ Swollen throat or voice change
- ☐ Swollen glands in neck
- ☐ Ringing in the ears
- ☐ Ear - Ache/Ringing/Drainage
- ☐ Sinus / Allergy problems
- ☐ Nose Bleeds
- ☐ Hearing Loss
- ☐ Other: _____
- ☐ None in this Category

Endocrine, Hematologic, and

Lymphatic:

- ☐ Thyroid problems
- ☐ Diabetes
- ☐ Excessive Thirst or urination
- ☐ Cold Extremities
- ☐ Heat or Cold intolerance
- ☐ Change in hat or glove size
- ☐ Dry skin
- ☐ Glandular or hormone problem
- ☐ Swollen Glands
- ☐ Anemia
- ☐ Easily Bruise or Bleed
- ☐ Phlebitis
- ☐ Transfusion
- ☐ Immune system disorder
- ☐ Other: _____
- ☐ None in this Category

Skin and Breasts:

- ☐ Rash or Itching
- ☐ Change in Skin Color
- ☐ Change in hair or nails
- ☐ Non-healing sores
- ☐ Change of appearance of a mole
- ☐ Breast Pain
- ☐ Breast Lump
- ☐ Breast Discharge
- ☐ Other: _____
- ☐ None in this Category

Women Only:

Are you pregnant?

- ☐ Yes - Due Date ____/____/____
- ☐ No - Last Menstrual Period ____/____/____

- ☐ Infertility
- ☐ Painful or Irregular periods
- ☐ Vaginal Discharge
- ☐ Other: _____
- ☐ None in this Category

Pregnancies with Outcome & Date:

Comments: _____

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.

Patient or Guardian Signature _____ Date _____

Treating Doctor Signature _____ Date _____

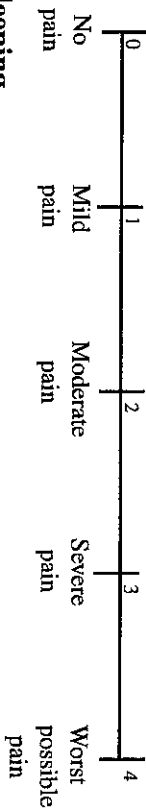
Patient No: _____

Functional Rating Index

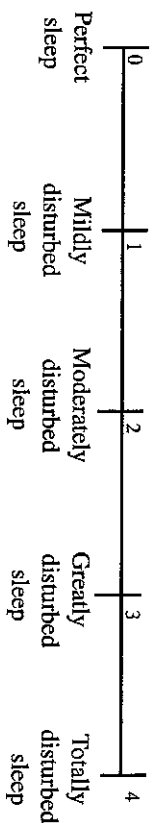
For use with Neck and/or Back Problems only.

In order to properly assess your condition, we must understand how much your **neck and/or back problems** have affected your ability to manage everyday activities. For each item below, please circle the number which most closely describes your condition right now.

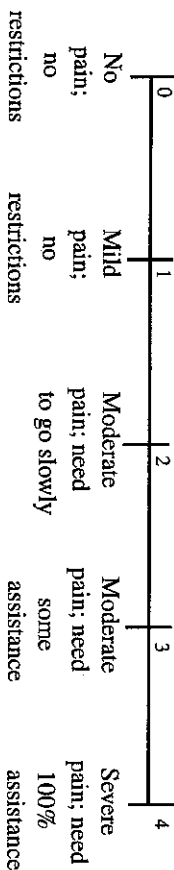
1. Pain Intensity



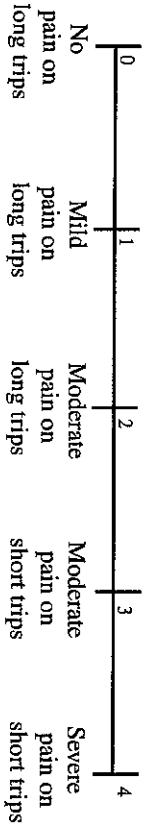
2. Sleeping



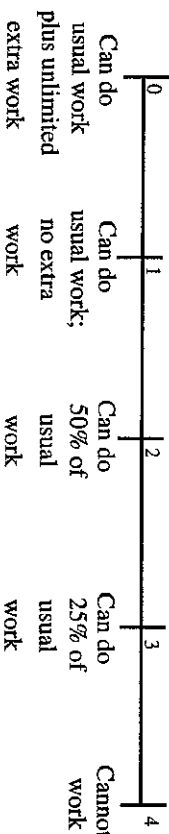
3. Personal Care (washing, dressing, etc.)



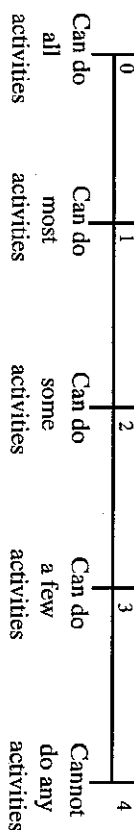
4. Travel (driving, etc.)



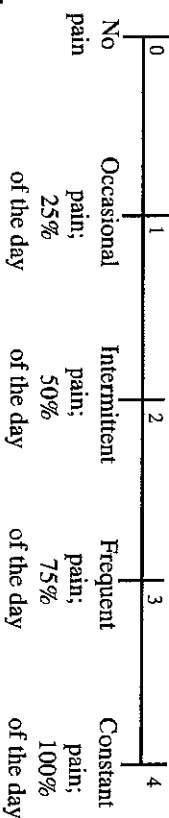
5. Work



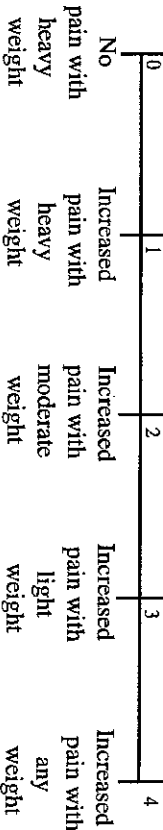
6. Recreation



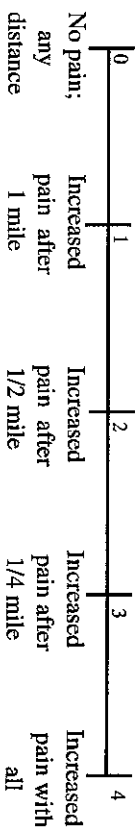
7. Frequency of pain



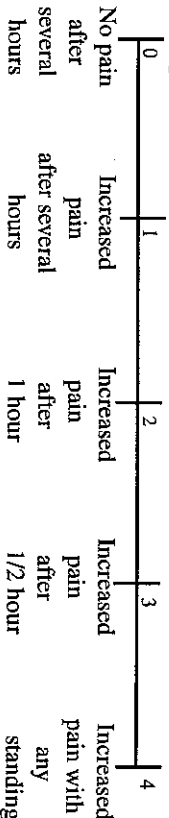
8. Lifting



9. Walking



10. Standing



Name _____ ID#/SS# _____ Plan ID _____ Total Score _____

PRINTED

Signature

Date

NEW LEAF CHIROPRACTIC

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www.drcurtisbegin.com

Health Insurance Portability & Accountability Act (HIPAA) Consent

Your Protected Health Information (PHI) will be used by this office or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office. You should review the Notice of Privacy Practices for a more complete description of how your PHI may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. You may review the Notice prior to signing this consent. You may request a copy of the Notice at the Front Desk. This office reserves the right to modify the Privacy Practices outlined in the Notice.

Requesting a Restriction on the Use or Disclosure of Your Information

You may request a restriction on the use or disclosure of your PHI. It is the policy of this office that it will continue to provide treatment for a patient who restricts consent to the use and disclosure of his/her PHI for the purposes of treatment, payment, or health care operations. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent

You may revoke this consent to the use and disclosure of your PHI. You must revoke consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected. Select an option below:

1. I, _____ (print name) acknowledge that I have reviewed the above information and give my permission to this office to use and disclose my PHI in accordance with the Privacy Practices.
2. I, _____ (print name) acknowledge that I have reviewed the above information and **DO NOT** give my permission to release any information to my insurance carrier or other health care professionals. I do understand that PHI will be used **within** the office for purposes of my care, to those individuals designated by the doctor.

Patient or Parent Signature: _____ Date: _____

Assignment of Benefits/Assignment of Cause of Action/Contractual Lien/ EHR

Our office will make every attempt to verify your policy benefits, however, this office and your insurance DOES NOT guarantee a quote of benefits for payment of service provided. Should your insurance provide chiropractic benefits; your insurance will be filed on a weekly basis as a courtesy to you. You will be responsible for your deductible and/or co-payment. Your insurance should pay within 45 days from the date in which it was filed. In the event that your insurance company does not pay in a timely manner, you may be asked to contact your insurance carrier.

If your insurance company mails a check directly to you for our services, you must bring the misdirected check to our office within 48 hours. Clinical Summary Report (CCR): I understand that a clinical summary report is created after each visit for the purpose of EHR and is available for my review. At this time, I am asking New Leaf Chiropractic 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 Rights and Conveyance of Lien Interest

I hereby execute and provide **Irrevocable Lien Interest and Assignment of Proceeds** to any cause of action that exists in my favor against any insurance company for the terms of the policy, including the exclusive, irrevocable right to receive payment for such services, make demand for payment, and prosecute and receive penalties, interest, court loss, or other legally compensable amounts owed by an insurance company in accordance with Article 21.55 of the Texas Insurance Code to cooperate, provide information as needed, and appear as needed to assist in the prosecution of such claims for benefits upon request. To any insurance company providing benefits of settlement of a claim, you are instructed that pursuant to this Irrevocable Lien Interest and Assignment of Proceeds to pay the total dollar amount of all sums which I owe on account to the above named doctor and treating facility within 30 days following your receipt of medical bills submitted by the doctor and/or treating facility. **I instruct checks to be made payable to New Leaf Chiropractic and payment to be sent to 686 Grapevine Highway, Hurst, Texas 76054.**

This demand specifically conforms to article 21.55 of the Texas Insurance Code, providing for attorney fees, 18% penalty, court cost, and interest from judgment, upon violation. In the event my insurance settlement proceeds are paid directly to my attorney, I hereby irrevocably instruct my attorney to withhold all such sums and amounts as are determined to be owed, due and payable on my account and remit payment of all such sums directly to the above named doctor and/or treating facility upon my settlement award(s).

Patient or Parent Signature: _____ Date: _____

Informed Consent for Treatment

I hereby authorize and release the doctor and any individual he may designate as his assistant to administer treatment, physical examination, x-ray studies, chiropractic care, or any clinical services that he deems necessary in my case. I understand that, as with any health care procedure, complications are possible following chiropractic manipulation and/or manual therapy techniques. The risks of complications due to chiropractic treatments have been labeled as "rare" and the probability of adverse reaction due to ancillary procedures is also considered "rare".

I hereby acknowledge that if I do not keep appointments as recommended to me by my treating doctor, he has complete right to terminate responsibility for my care and relinquish any disability granted me within a reasonable period of time. I understand that failure to complete my recommended treatment plan may jeopardize my case.

Patient or Parent Signature: _____ Date: _____

Consent for Treatment of Minor

I, the parent or legal guardian of _____ (minor child's name), hereby give my permission to New Leaf Chiropractic to treat said child.

Patient or Parent Signature: _____ Date: _____