INITIAL CHILD & ADOLESCENT QUESTIONNAIRE

Child's Name:____________________________________ Date:____
Birth Date:_________________
Mom Name:_____________________________________ Dad Name:_____________________________________
Address:____
____
Telephone # Home_______________________________ Work:__________________ Cell:________________________
Insurance:___________________________ Insured Name:__________________________ Insured DOB:_____________

(Independent Health & Empire Insurance Only)

Mainly for Moms:

Tell us about your pregnancy:

Did you carry to full term?:____
Describe any complications and when they occurred:____
____

Did you consume alcohol during your pregnancy:_________ How much?______________________________________
Did you smoke?___________ How much?________________ How long?______________________________________
Did you take any medication during your pregnancy?__________________
For What?______________________________________ What type?____
Any exposures to ultrasound?____How many?________________

Tell us about your delivery and birth of this child:

Did you use a midwife?___________ Hospital?____________ Obstetrician?_________________________________
Did you have a C-Section?___________________ Were forceps used?_______________________________________
Vacuum Extraction?_________________________ Were you induced?____
Did you have an Epidural?____________________ Was it a difficult birth?___________________________________
What was the baby's APGAR score?__________________ at 5 minutes?_____________________________________
Did you breastfeed?__________How long?__________________________ What formula after?___________________

As a baby/toddler, (birth to 4 yrs), did any of the following occur?

___ Fall from a changing table
___ Tumble down stairs
___ Fall out of a crib
___ Involved in car accident
___ Fall off playground equipment
___ Play in Jolly Jumper
___ Frequent ear infections
___ Tonsillitis
___ Reaction to vaccination
___Frequent crying spells
___ Frequent fevers
___ Frequent bouts of diarrhea
___ Constipation
___ Sleeping problems
___ Frequent colds
___ Colic
___ Did not gain weight
___ Other _________________________________

Please explain the above: ____
____

As a young child, (5-12yrs), did any of the following occur?

___ Fall from a tree
___ Fall off a bicycle
___ Fall off playground equipment
___ Sports accident
___ Car accident
___ Stomach pains
___ Scoliosis
___ Bed wetting
___ Hyperactivity/Autism
___ Learning difficulties
___ Asthma
___ Allergies
___ Leg/knee pain
___ Other __________________

Please explain the above:____

Tell us about any vaccinations your child has had:____
____
____
Any reaction to any of these?____

As a child or adolescent, has your child experienced any of the following?:

___ Headaches ___ Numbness in arms/hands ___ foot/ankle/knee pains
___ Dizziness ___ Arm/wrist pains ___ Tingling in arms/legs
___ Ringing in ears ___ Sleeping problems ___neck/back pains
___ Asthma ___ Allergies ___ Shoulder pains
___ Hyperactivity ___ Stomach problems ___ "growing pains"
___ Fatigue ___ Weight gain/loss ___ Other ______________________

Please explain any of the above:____
____

Which of the problems you have checked off is the worst?____
Is this problem: Constant__________ Frequent__________ Occasional___________ Intermittent____________________

How long has it persisted?____
When it is at its worst, how does it make your child feel?____
____
What have you done about it that has NOT worked?____
____
What makes it worse?____
What effect does this problem have of your child's body functions? ____
____
____
On his/her participation in daily activities?____

Describe any hospital stays:____
____

Approximately how many times have antibiotics been prescribed and for what conditions? ______________________
____
____

List any medications our child is currently taking: ____
____

To summarize, what is your purpose for this appointment?____
____
____

Is there anything else you feel we should know?____
____
____

Signature of guardian or parent:____ **Date:**_________________________

Office Policies

EFFECTIVE 1/1/15

This form outlines our office policies and expectations. By initialing on the left the patient agrees to our office policies. This form must be filled out before your initial visit.

Initial:

_____ **Payment Policy**

In order to facilitate patient visits, all payments are expected directly at the beginning of each patient visit. **Forestville Chiropractic accepts cash, check or credit card payments only.** Checks should be made out to Dr. Jessica Mierzwa, and written prior to the start of the office visit. **Inability to provide the payment at the time of service will incur a $5 service charge for each visit not paid.** A payment receipt will be presented upon request on the day of service ONLY. If receipts are requested at a later date, they will be provided at a charge of $1 per receipt.

_____ **No Shows/Cancellations**

We reserve the right to charge you $35 for any missed appointments without 24hrs notice.

_____**Financial Agreement**

Our fees are as follows: $60 initial visit and $35 for follow-up appointments. If you have not been to the office for a year there is an additional re-evaluation fee of $10. If you have not been to the office for 5 years or more, you will be considered a new patient.

_____**Insurance**

We no longer accept cases due to work related injuries or auto accidents. By initialing here the patient confirms that he/she has NOT been involved in a work related accident or motor vehicle accident. Patient is also aware that their primary insurance company may NOT be billed for treatment following such injuries as it constitutes insurance fraud. If you've been involved in such an accident please let us know at the front desk and we'll be happy to refer your case to another practitioner. IF you are filling this out online and would like to be referred to another practitioner feel free to use our contact form or fall the office during regular business hours.

By signing below you verify that you do not have any questions about this form and that you agree to all the outlined terms.

Signature: _________________________________ Date:_________________________