

PEDIATRIC
QUESTIONNAIRE



N58 W39799 Hwy 16
OCONOMOWOC, WI 53066
(262) 567-4497
TRAUBCHIRO@GMAIL.COM

TODAY'S DATE: _____

Child's Name: First _____ MI _____ Last _____ Age: _____

Date of Birth: _____ Sex: F or M How does your child like to be addressed: _____

Mother's Name: _____ Phone #: (____) _____

Father's Name: _____ Phone #: (____) _____

Email: _____

Address: _____

City: _____ State: _____ Zip: _____

Pediatrician: _____ Last Visit Date: _____

Has your child seen a chiropractor before? Y / N Name: _____

Current Condition:

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

When did the condition begin? _____ How did the problem start? _____

Medical History:

Height or length: _____ Weight: _____ Birth length: _____ Birth Weight: _____

Current medications/vitamins/supplement: _____

Surgeries or hospitalizations: _____

Major Illnesses, Accidents or Injuries: _____

Food/environment/drug allergies: _____

Labor and Delivery:

Child's birth was: Vaginal Scheduled C-Section Emergency C-Section Full Term: Yes No

Any complications or interventions: _____

Review of Symptoms:

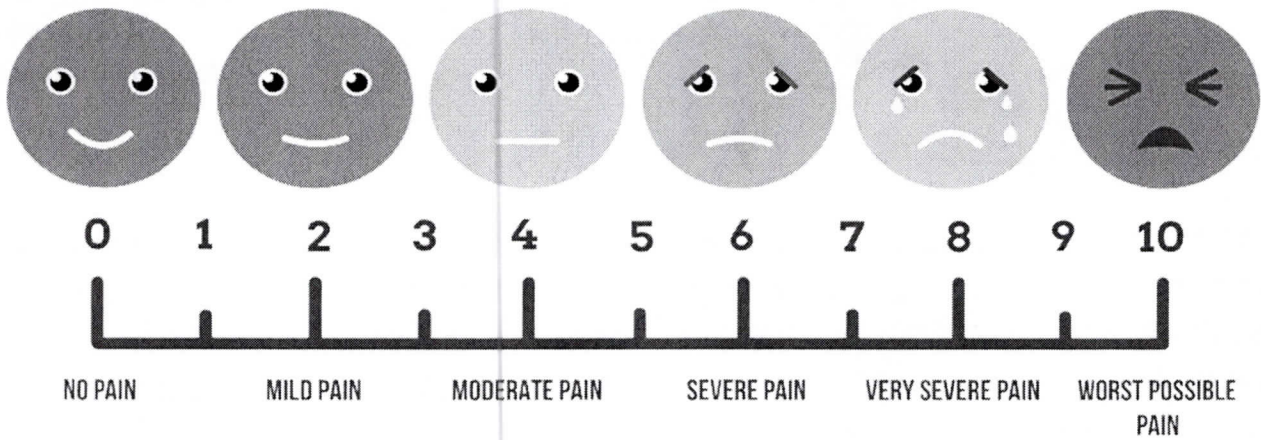
Please check if your child has had any of the following:

____ Headaches
____ Postural Imbalances
____ Growing Pains
____ Scoliosis
____ Tonsillitis
____ Asthma
____ Torticollis

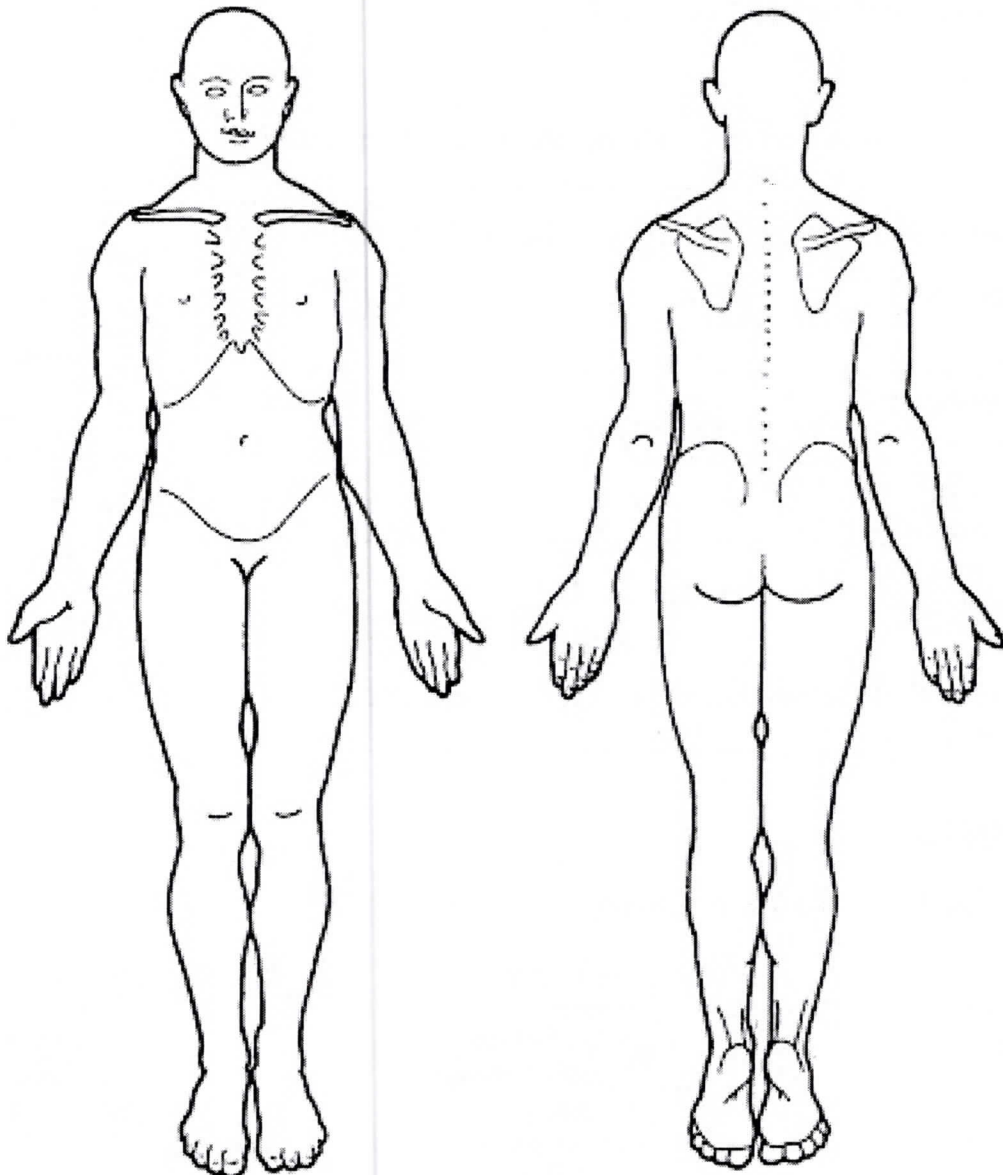
____ Ear Infections
____ Seizures
____ Sleep Problems
____ Digestive Problems
____ Bedwetting
____ PDD/Autism
____ ADD/ADHD

____ Frequent Fever
____ Colic
____ Learning Difficulties
____ Acid Reflux
____ Hip Dysplasia
____ Allergies

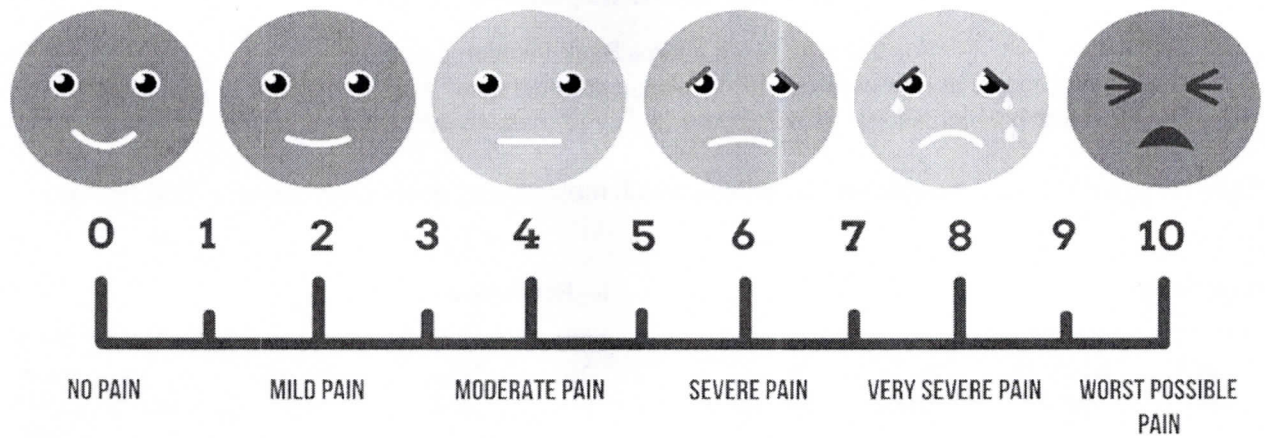
Name: _____ Date: _____



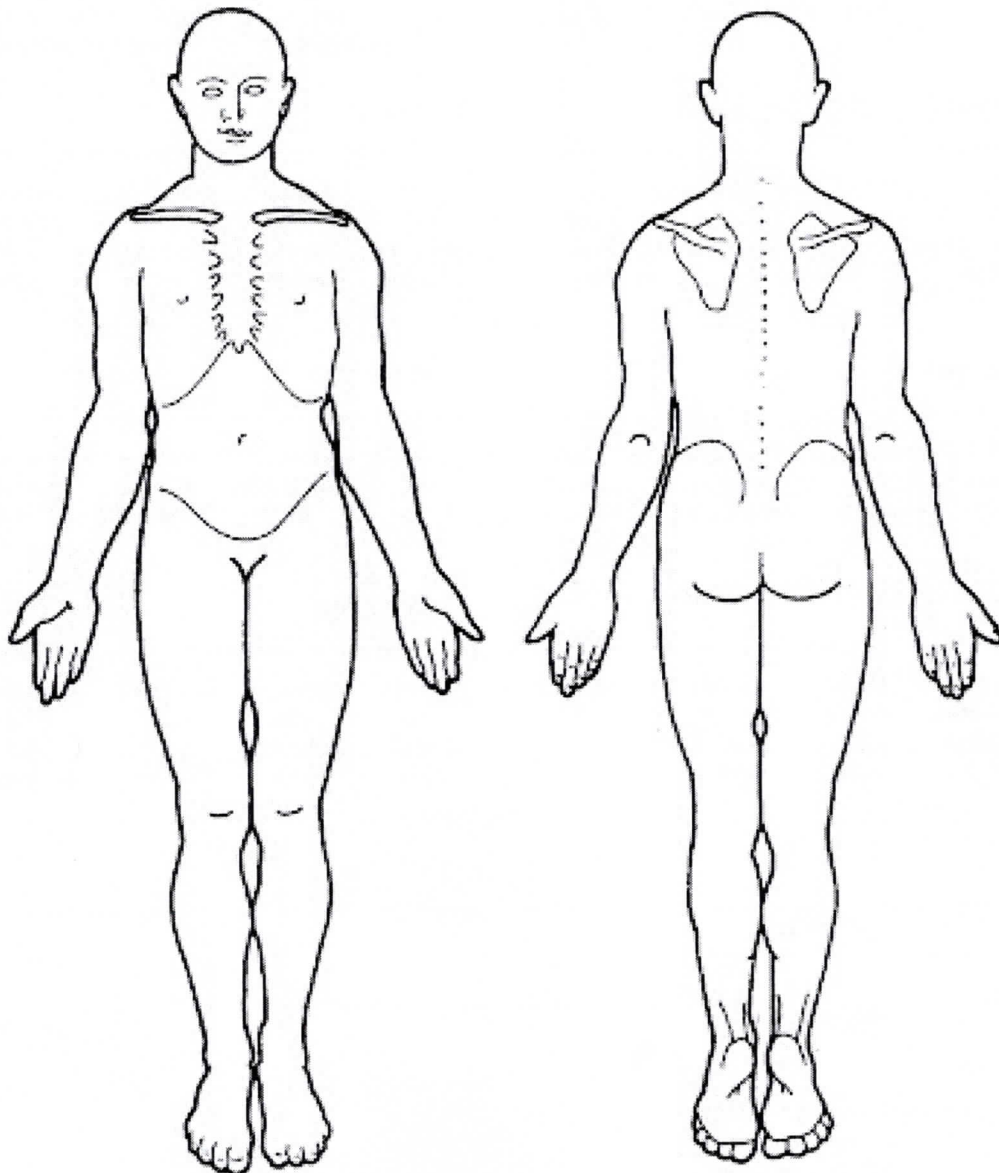
Circle a number above to describe your pain intensity AND mark or circle on the bodies below to show the location of any symptom(s) you have been experiencing recently.



Name: _____ Date: _____



Circle a number above to describe your pain intensity AND mark or circle on the bodies below to show the location of any symptom(s) you have been experiencing recently.



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 one choice which most closely describes your condition right now.

1. Pain Intensity

No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain
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6. Recreation

No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain
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2. Sleeping

Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep
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7. Frequency of Pain

No pain	Occasional pain; 25% of the day	Intermittent pain; 50% of the day	Frequent pain; 75% of the day	Constant pain; 100% of the day
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3. Personal Care (washing, dressing, etc.)

No pain no restrictions	Mild pain no restrictions	Moderate pain; need to go slowly	Moderate pain; need some assistance	Severe pain; need 100% assistance
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8. Lifting

No pain w/heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight
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4. Travel (driving, etc.)

No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain on short trips
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9. Walking

No pain any distance	Increased pain after 1 mile	Increased pain after 1/2 mile	Increased pain after 1/4 mile	Increased pain with all walking
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5. Work

Can do usual work plus unlimited extra work	Can do usual work no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot work
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10. Standing

No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after 1/2 hour	Increased pain with any standing
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Name _____

PRINTED

Signature _____

Date _____

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

The Nature of Chiropractic Treatment: The doctor will perform a physical examination. X-rays may be taken to evaluate your condition. The doctor will use his/her hands or a mechanical device in order to move our joints. You may feel a "click" or "pop" similar to the noise produced when a knuckle is "cracked," and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound, or traction maybe also be used. Exercises may be recommended.

Benefits of Chiropractic Treatment: Many or most patients will feel improvement in motion, decreased muscle and joint pain and improved well-being after a series of chiropractic adjustments.

Possible Risk: As with any health care procedure, complications are possible following chiropractic treatment. Complications could conceivably include fracture of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves, or spinal cord. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, urns, or other minor complications. X-rays produce ionizing radiation. There are reported cases of stroke associated with visits to medical doctors and/or chiropractors. The best quality scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke; rather , indicate that patients may be consulting medical doctors and/or chiropractors for symptoms of headache and neck pan when they are in the early stages of a stroke. The possibility of such injuries occurring in association with chiropractic treatment is extremely remote.

Probability of Risk Occurring: The risk of complications due to chiropractic treatment have been described as "rare" to "extremely rare".

Other treatment options which could be considered are the following:

- *Over-the-counter analgesics.* The risk of these medications include irritation to stomach, liver, and kidneys, increased cardiovascular risk, and other side effects in a significant number of cases.
- *Medical care,* typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these prescription drugs include all side effect as above, plus patient dependence in a significant number of cases.
- *Hospitalization* in conjunction with medical care adds risk of exposure to medical error, infection and other complications in significant number of cases.
- *Surgery* in conjunction with medical care, adds the risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

Risk of Remaining Untreated: Delay of treatment allows formation of adhesions, scar tissue, and other degenerative changes. These changes can further reduce skeletal mobility and induce chronic pain cycles. It is quite probable that the delay of treatment will complicate the condition and make future rehabilitation more difficult,

I have had the above unusual risks of my case explained to me.

I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and the benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and hereby give my full consent to treatment. This informed consent will remain in effect unless there are significant changes in my diagnosis or my legal status. I have the right to withdraw my consent at any time, upon written notice. I have the right to refuse treatment at any time.

Printed Name: _____ **DOB:** _____

Signature: _____ **Date:** _____

Staff Initials: _____

Traub Chiropractic Care Center
N58 W39799 Hwy 16 Oconomowoc, WI 53066
Ph: 262-567-4497 Website: traubchiropractic.com

Patient Name: _____ **DOB:** _____

PAYMENT AUTHORIZATION

I request that payment of authorized health benefits be made to Traub Chiropractic Care Center for any services given to me by the provider. I authorize to any holder of medical information about me to be released to process any claim and any information needed to determine these benefits or the benefits payable for related services. This authorization is in effect until I choose to revoke.

Traub Chiropractic may verify my chiropractic coverage; however, this is an estimation of benefits and not a guarantee of coverage. Any estimated copays are due at time of service. I understand I am liable for any non-covered charges and any remaining patient responsibility amount. Missed appointments without prior notification will result in a \$25 fee.

Signature: _____ **Date:** _____

PRIVACY PRACTICE ACKNOWLEDGEMENT

I understand that a copy of the HIPAA policy is available for me at any time
and a copy is posted in a common area of the clinic.

Signature: _____ **Date:** _____

Contact for Information, Questions, or Concerns

If you have questions or concerns about your privacy rights, these privacy-related policies or the information in this notice, please contact the doctor or the office manager where you are receiving care.

CONSENT TO TREAT A MINOR

I hereby authorize Traub Chiropractic Care Center's doctors, together with whomever my treating doctor may designate as an appropriate individual(s) to administer chiropractic care, including X-rays, and appropriate adjunctive services as my treating chiropractor deems is necessary to my child. I acknowledge that I have legal authority to provide such written consent on behalf of such child/ward.

Signature of Parent or Guardian: _____ **Date:** _____

Relation to Child: _____