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:

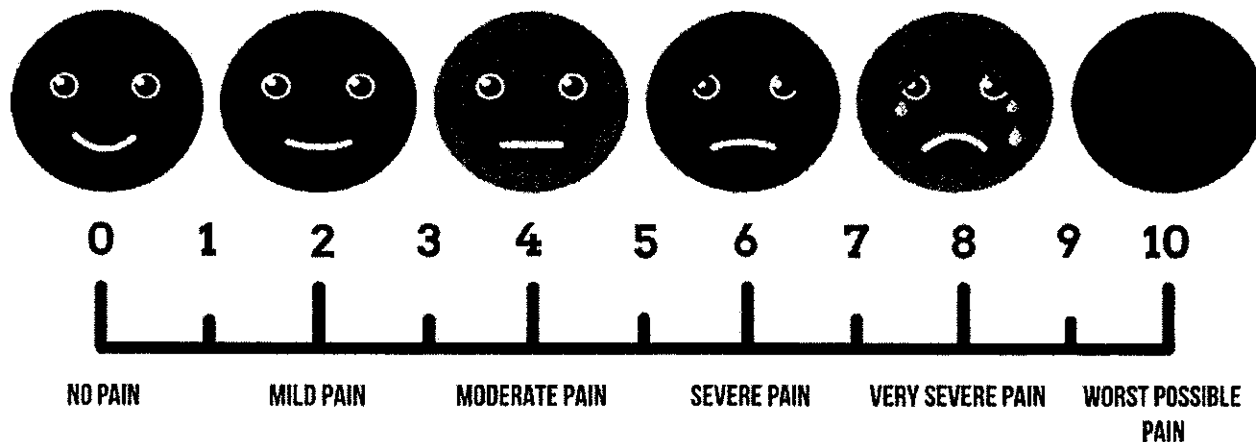
Please check if your child has had any of the following:

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

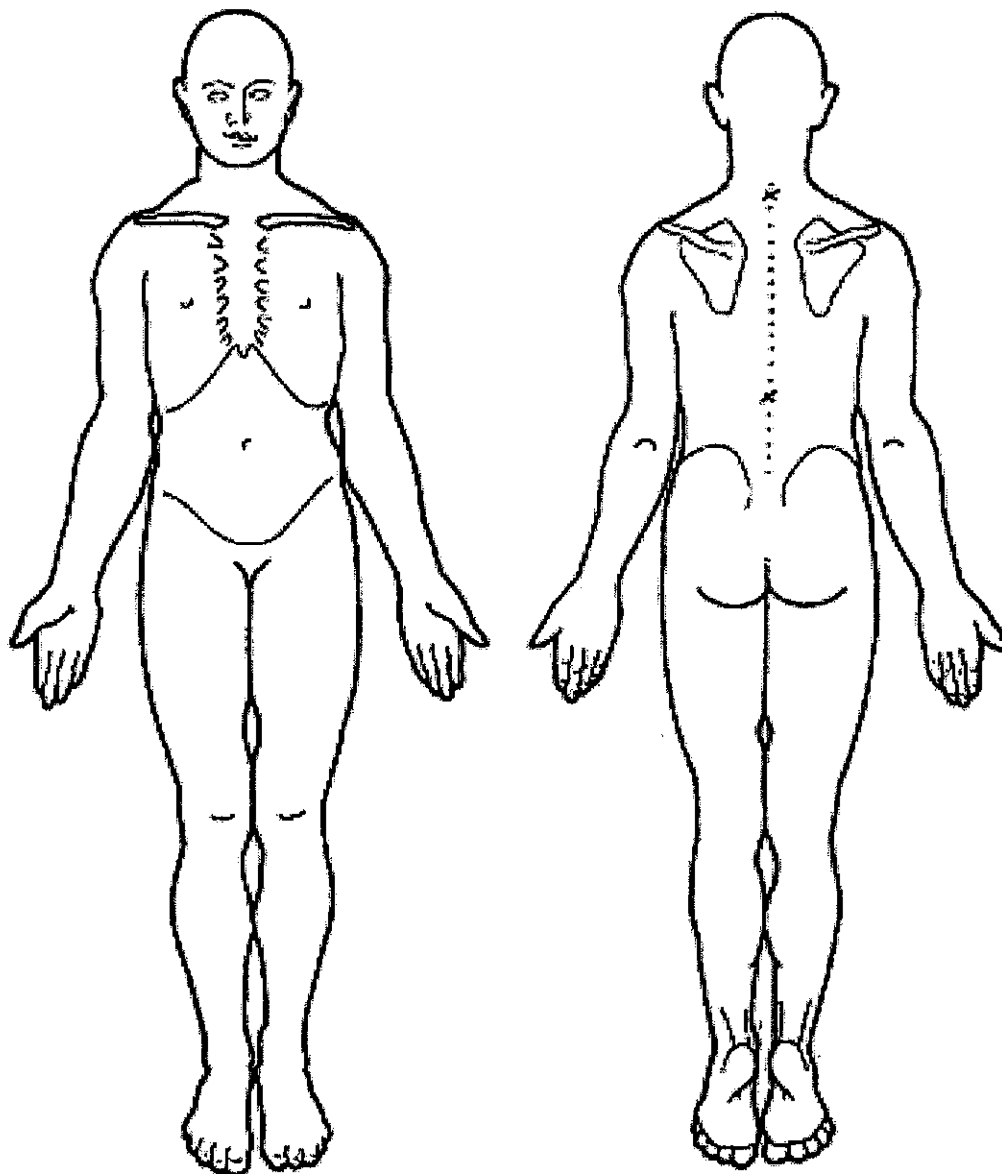
____ Ear Infections
____ Seizures
____ Sleep Problems
____ Digestive Problems
____ Bedwetting
____ PDD/Autism
____ ADD/ADHD

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

Name: ______________________________ Date: ______________________



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



Traub Chiropractic Care Center
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Ph: 262-567-4497/traubchiro@gmail.com
Website: traubchiropractic.com

INFORMED CONSTENT 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: __________

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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.

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: ______________________________

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AUTHORIZATION FOR TEXT AND EMAIL

Patient Name ______________________________ Date of Birth: ______________

I understand that:

- Text messages and emails are inherently unsecure because they are transmitted over a public network onto a personal telephone and as such there are inherent risks in using this type of communication. Information texted to me could be received and read by an unauthorized third party.
- It is my responsibility to keep my mobile number and email up to date with Traub Chiropractic Care Center.
- I should not send PHI or ePHI to Traub Chiropractic Care Center in a message because of the unsecure nature of text messages and emails.
- I may be charged for text messages by my wireless carrier.
- This authorization is voluntary and I have the right to refuse to sign it.
- Treatment will not be conditional on whether I sign this authorization.
- By signing this form, I am allowing Traub Chiropractic Care Center to send me messages in order to:
  - Notify me of appointment confirmations, reminders or missed appointments
  - Special messages, promotions, office updates
  - Other ______________________________
- Traub Chiropractic Care Center will not send PHI or sensitive PHI in a message.
- If I sign this authorization, I may revoke (cancel or opt out) it later, at any time, by replying "STOP" to a text or unsubscribing from email communications.

Signature(s)

Patient signature ______________________________ Date ______________

Sign below if you are a personal representative of the patient.

Representative signature ______________________________ Date ______________

Print Name ______________________________ Relationship to Patient ______________

Definitions:

Protected Health Information (PHI): PHI means information about a patient, including demographic information that may identify a patient, that relates to the patient's past, present or future physical or mental health or condition, related health care services or payment for health care services.

Sensitive Protected Health Information (SPHI): SPHI means Protected Health Information that pertains to particularly sensitive information, as defined by state law, such as (i) an individual's HIV status or treatment of an individual for an HIV-related illness or AIDS, or (ii) an individual's substance abuse condition or treatment of an individual for mental illness.