



Pediatric 2-12yoa Health Questionnaire



Welcome to Adjusting the World Chiropractic

Name: _____ Date: _____

Please make sure you have completed the **Patient Online Intake form from our website.**

The following pages are designed to give us further information about your health and lifestyle, which will allow us to better serve you. It also includes forms requiring signatures, including privacy (HIPAA), our financial policy, and informed consent for treatment. Thank you and we look forward to serving you!

Wellness Profile (Infant History)

Throughout the exam, the doctor will be searching for one thing: the CAUSE of your child's health challenge. Chiropractic wellness care seeks to find the causes of a health challenge, rather than simply trying to artificially alleviate the symptoms through chemical manipulation. The following questions are vital to finding the cause of your current health condition and finding solutions to your health challenge. Please take your time answering these questions, including anything that you may feel is related to your child's current complaints.

Birth History	Location: Home Birthing Center Hospital Provider: Midwife OB/GYN Name of provider: _____ Duration of Gestation: _____ weeks Duration of Birth: _____ Please circle any that apply: Induction Forceps Vacuum Extraction C-Section Medications given to mother during labor/delivery? Yes No If yes, what? _____ Describe any complications during or immediately after birth: _____ _____
	Was your child alert and responsive within 12 hours after delivery? Yes No If no, explain: _____
Development	Did your child have any developmental delays? Respond to Sound _____ Hold up Head _____ Crawl _____ Speak _____ Follow an Object _____ Sit Alone _____ Walk _____ Does or did your child have any of the following: <input type="checkbox"/> Difficulty with crawling (on all fours) <input type="checkbox"/> Did not crawl on all fours <input type="checkbox"/> Difficulty using utensils <input type="checkbox"/> Difficulty learning to ride a bike <input type="checkbox"/> Appears clumsy <input type="checkbox"/> Difficulty tying shoes <input type="checkbox"/> Difficulty learning to read <input type="checkbox"/> Difficulty with writing <input type="checkbox"/> Difficulty buttoning clothing <input type="checkbox"/> Difficulty sitting still/paying attention <input type="checkbox"/> Difficulty with walking/running <input type="checkbox"/> Poor hand-eye coordination Do sleeping patterns seem normal to you? Yes No If no, explain: _____
	Number of bowel movements per day: _____ Consistency of stools: firm loose normal
Move Well	How does your child spend the majority of their day? Seated Standing Other: _____ Computer/TV use: <30 min/day 30-60 min/day 2hr/day 3hr/day >4hr/day
	Rate the following on a scale of 1-10 (10 being best): Posture: _____ Sleep: _____ Hours per day? _____ Position _____ Does your child play outside regularly? Yes No Do you believe your child gets enough physical activity? Yes No Does your child play sports? Yes No Which Sports? _____ Other activities: _____

Wellness Profile (continued)

Think Well	<p>How well does your child handle stress? _____</p> <p>Rate the following on a scale of 1-10 (10 being best):</p> <p>Your child's stress level: _____</p> <p>Daily Positive Thoughts: _____</p> <p>Handle traumatic events: _____</p> <p>Doing things they love: _____</p>
Early Feeding-Eat Well	<p>Was your child breast-fed? Yes No How long? _____ Any troubles with feeding? Yes No</p> <p>Formula introduced at age _____ Solid Food at age _____</p> <p>Any food/drink allergies or intolerance? Yes No If yes, what foods: _____</p> <p>During pregnancy did the mother smoke? Yes No Drink alcohol? Yes No Use recreational drugs? Yes No</p> <p>Please list any illness of the mother during pregnancy: _____</p> <p>Any drugs or supplements taken by the mother during pregnancy: _____</p> <p>Any exposure to ultrasound? Yes No If yes, how many and what was the medical reason? _____</p> <p>_____</p> <p>Any invasive procedures (amniocentesis, CVS)? Yes No If yes, give reason: _____</p> <p>Any smokers living in the home? Yes No Exposure to Fluoride (water, toothpaste)? Yes No</p> <p>Child's sugar consumption (soft drinks, candy, etc.) None Low Medium High</p> <p>Has your child had any vaccinations? Yes No If yes, any adverse vaccine reactions? Yes No</p> <p>Which vaccinations? _____</p> <p>Has your child ever taken antibiotics? Yes No If yes, how many times? _____</p> <p>_____</p> <p>How many servings does your child have per day: Fruits? ____ Vegetables? ____ Meat? ____ Dairy? ____</p> <p>How frequently does your child eat per day? 1-2 meals 3-4 meals 5-6 meals snack all day</p> <p>Drink Bottled water? Yes No</p> <p>Drink Soda? (Diet or Regular) Yes No</p> <p>Consume caffeine? Yes No</p> <p>Do you have an air purifier? Yes No</p>
Comment	<p>Use this space to add any additional comments or details regarding the health of your child.</p> <p>_____</p> <p>_____</p> <p>_____</p>
Family	<p>At our office we are not only interested in your health and wellbeing but also that of your family and loved ones. Please mention below any health conditions or concerns you may have about your:</p> <p>Other Children: _____ Spouse: _____</p> <p>Mother: _____ Father: _____</p> <p>Brother(s): _____ Sister(s): _____</p>

I consent to a professional and complete chiropractic examination and to any radiographic examination that the doctor deems necessary for my child. I understand that any fee for service rendered is due at the time of service and cannot be deferred to a later date.

Parent's Signature _____ Date: _____

Financial Policy

IN-NETWORK GROUP OR INDIVIDUAL INSURANCE

Your insurance is an agreement between you and your insurance company, not between your insurance company and our office. We cannot be certain if your insurance covers Chiropractic, although most policies do provide coverage. The amount they pay varies from one policy to another. We will call to verify your benefits; however, the benefit quote obtained from your insurance company is not a guarantee of payment. As a courtesy to you, our office will complete any necessary insurance forms at no additional charge, and file them with your insurance company to help you collect. It is to be understood and agreed that any services rendered are charged to you directly and you are personally responsible for payment of any non-covered services, deductibles, co-insurance or co-pays. Your portion of charges are immediately due upon processing by insurance. **We will provide you with a monthly statement however we strongly encourage you to pay your anticipated amount due by the end of every week to avoid past due balances and interest charges.**

PATIENTS WITH OUT OF NETWORK INSURANCE

If you have insurance coverage with a company that we are not currently in network with we will attempt to verify your insurance and share the information with you during your report of findings on your 2nd visit. As a courtesy we will submit your claims; however we do not accept assignment with all insurance companies. We will let you know if we can accept assignment for you. When assignment is accepted the reimbursement will be sent directly to our office and you will only be asked to pay your anticipated patient portion and then any remainder amount due after insurance is complete. If we do not accept assignment, insurance reimbursement will be sent to you and your account will be handled in our office as a Cash account. Please see: "CASH PAYING..."

PERSONAL INJURY, AUTOMOBILE ACCIDENTS & WORKER'S COMPENSATION

Separate financial policies are enforced for PI and WC cases. Refer to Adjusting the World Paperwork for details.

MEDICARE

We accept assignment from Medicare and we will submit your claims for you. The check is usually sent directly to our office. The ONLY services that Medicare will cover when provided by a Chiropractor is manual manipulation of the spine. Maintenance and preventative service is not covered. Medicare pays 80% of the allowable fee once the deductible has been met. You are required to pay the deductible and the remaining 20%. All other services we provide are NONCOVERED. These services include, but are not limited to, x-rays, examinations, therapies, orthotics, supports, and/or nutritional supplements. Medicare patients are fully responsible for charges of non-covered services. Maintenance and preventative service is not covered. Secondary insurance may or may not pay for these non-covered services. Please see IN-NETWORK GROUP OR INDIVIDUAL INSURANCE for payment policy.

FLEX PLANS/MEDICAL SAVINGS ACCOUNTS

If you have a flex spending account we will be happy to provide you with a statement of your charges for reimbursement. (First statement of each year is no charge. Each subsequent statement will have a \$5 charge)

INSURANCE FORMS/PAYMENT

If you receive any correspondence from your insurance carrier pertaining to the care you have received at this office or a request of more information regarding your care, please bring it in as soon as possible. It is very important that we keep your file as up to date as possible. Occasionally, either by mistake, or due to provisions in your policy, the check issued by the insurance company for payment of services rendered in our office, may come to you instead of our office. If you should receive any unexpected check in the mail, please contact us to see if it does represent payment of your bill here.

SECONDARY INSURANCE

Please inform us of any secondary insurance.

CASH PAYING PATIENTS

If you do not fall under any of the other categories of payment, you are a **CASH** patient. Since there is no insurance to bill and there are no others responsible for your account, you are expected to pay for your visit at the time of service. You may pay with CASH, CHECK, or CREDIT CARD. We do not carry patient balances unless you have been approved for a payment plan through Care Credit, or have signed up for a monthly payment plan. For Care Credit applications and additional information on how to use Care Credit's no interest payment plans, please ask ...We're happy to help!

I have read and understand the payment policy of Adjusting the World Chiropractic. I understand that my insurance is an arrangement between myself and my insurance company, NOT between Adjusting the World Chiropractic and my insurance company. I request that Adjusting the World Chiropractic prepare the customary forms at no charge so that I may obtain insurance benefits. I also understand that if my insurance does not respond within 60 days, or if I suspend or terminate my schedule of care as prescribed by the doctors at Adjusting the World Chiropractic that fees will be due and payable immediately.

Patient's signature (or guardian if patient is a minor)

Date