Pediatric Patient Questionnaire

Confidential Patient Information

Child's Name: | Parent/Guardian Name(s):

Street Address: | City, State, Postal Code:

Cell Phone: | Other Phone: | Child's Sex:

Email: | Child's SSN: | Birthdate: | Age:

How did you hear about us? | Height: | Weight:

Who is your primary care physician?

Is your child receiving care from any other health professionals? ○ Yes ○ No
– If yes, please name them and their specialty:

Please list any drugs/medications/vitamins/herbs or other that your child is taking:

Current Health Conditions

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

When did the condition first begin? | How did the problem start? ○ Suddenly ○ Gradually ○ Post-Injury

Has your child ever received care for this condition? ○ Yes ○ No
– If yes, please explain:

Is this condition: ○ Getting worse ○ Improving ○ Intermittent ○ Constant ○ Unsure

What makes the problem better? | What makes the problem worse?

Health Goals for Your Child

What are your top three health goals for your child?

1. _____
2. _____
3. _____

What would you like to gain?

○ Resolve existing condition
○ Overall wellness
○ Both

Has your child ever visited a chiropractor? ○ Yes ○ No – If yes, what is their name:

– What is their specialty: ○ Pain Relief ○ Physical Therapy & Rehab ○ Nutrition ○ Subluxation-based ○ Other:

Pregnancy & Fertility History

Please tell us about your pregnancy:

Any fertility issues? ○ Yes ○ No If yes, please explain: _____

Did mother smoke? ○ Yes ○ No If yes, how often? _____

Did mother drink? ○ Yes ○ No If yes, how often? _____

Did mother exercise? ○ Yes ○ No If yes, please explain: _____

Was mother ill? ○ Yes ○ No If yes, please explain: _____

Any ultrasounds? ○ Yes ○ No If yes, please explain: _____

Please explain any noticable episodes of mental or physical stress during your pregnancy:

Please explain any other concerns or notable remarks about your child's conception or pregnancy:

Labor & Delivery History

Child's birth was: ○ Natural vaginal birth ○ Scheduled C-section ○ Emergency C-section – At how many weeks was your child born?

Where was your child born? – Who delivered your baby?

Please indicate any applicable interventions or complications:
○ Breech ○ Induction ○ Pain meds ○ Epidural ○ Episiotomy ○ Vacuum extraction ○ Forceps ○ Other:

Please describe any other concerns or notable remarks about your child's labor and/or delivery:

Child's birth weight: Child's birth height: APGAR score at birth: APGAR score after 5 min.:

Growth & Development History

Is/was your child breastfed? ○ Yes ○ No – If yes, how long? Difficulty with breastfeeding? ○ Yes ○ No

Did they ever use formula? ○ Yes ○ No – If yes, at what age? – If yes, what type?

Did/does your child suffer from colic, reflux, or constipation as an infant? ○ Yes ○ No
– If yes, please explain:

Did/does your child frequently arch their neck/back, feel stiff, or bang their head? ○ Yes ○ No
– If yes, please explain:

At what age did the child: Respond to sound:_____ Follow an object:_____ Hold their head up:_____ Vocalize:_____
Teethe:_____ Sit alone:_____ Crawl:_____ Walk:_____ Begin cow's milk:_____ Begin solid foods:_____

Please list any food intolerance or allergies, and when they began:

Please list your child's hospitalization and surgical history (including the year):

Please list any major injuries, accidents, falls and/or fractures your child has sustained in his/her lifetime (including the year):

Have you chosen to vaccinate your child? ○ No ○ Yes, on a delayed or selective schedule ○ Yes, on schedule
– If yes, please list any vaccine reactions:

Has your child received any antibiotics? ○ Yes ○ No
– If yes, how many times and list reason:

Night terrors or difficulty sleeping? ○ Yes ○ No – If yes, please explain:

Behavioral, social or emotional issues? ○ Yes ○ No – If yes, please explain:

How many hours per day does your child typically spend watching TV, computer, tablet or phone?

How would you describe your child's diet? ○ Mostly whole, organic foods ○ Pretty average ○ High amount of processed foods

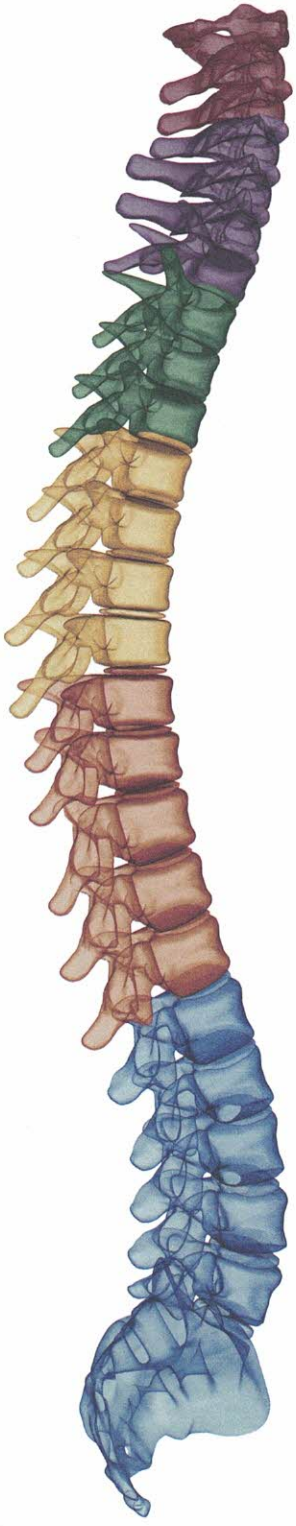
Acknowledgement & Consent

Parent/Guardian Signature: _____ Date: _____

Patient Review of Systems

THE NERVOUS SYSTEM CONTROLS AND COORDINATES ALL ORGANS AND STRUCTURES OF THE HUMAN BODY

Please check the corresponding boxes for each symptom or condition you have experienced – including both past and present.



REGIONS	FUNCTIONS	SYMPTOMS			
		PAST	PRESENT	PAST	PRESENT
Cervical	• Autonomic Nervous System • ENT System • Vision, Balance & Coordination • Speech • Immune System • Digestive System • Nerve Supply to Shoulders, Arms & Hands • Sympathetic Nucleus • Metabolism	☐	☐ Colic & Excessive Crying	☐	☐ Epilepsy & Seizures
		☐	☐ Ear & Sinus Infections	☐	☐ Sensory & Spectrum
		☐	☐ Allergies & Congestion	☐	☐ ADD / ADHD
		☐	☐ Immune Deficiency	☐	☐ Focus & Memory Issues
		☐	☐ Headaches & Migraines	☐	☐ Anxiety & Stress
		☐	☐ Vertigo & Dizziness	☐	☐ Balance & Coordination
		☐	☐ Sore Throat & Strep	☐	☐ Speech Issues
		☐	☐ Swollen Tonsils & Adenoids	☐	☐ TMJ / Jaw Pain
		☐	☐ Vision & Hearing Issues	☐	☐ Stiff Neck & Shoulders
		☐	☐ Low Energy & Fatigue	☐	☐ Depression
		☐	☐ Difficulty Sleeping	☐	☐ High Blood Pressure
		☐	☐ Pain, Numbness & Tingling in Arms to Hands	☐	☐ Poor Metabolism & Weight Control
Upper Thoracic	• Upper G.I. • Respiratory System • Cardiac Function	☐	☐ Reflux / GERD	☐	☐ Bronchitis & Pneumonia
		☐	☐ Chronic Colds & Cough	☐	☐ Functional Heart Conditions
		☐	☐ Asthma		
Mid Thoracic	• Major Digestive Center • Detox & Immunity	☐	☐ Gallbladder Pain / Issues	☐	☐ Indigestion & Heartburn
		☐	☐ Jaundice	☐	☐ Stomach Pains & Ulcers
		☐	☐ Fever	☐	☐ Blood Sugar Problems
Lower Thoracic	• Stress Response • Filtration & Elimination • Gut & Digestion • Hormonal Control	☐	☐ Behavior Issues	☐	☐ Allergies & Eczema
		☐	☐ Hyperactivity	☐	☐ Skin Conditions / Rash
		☐	☐ Chronic Fatigue	☐	☐ Kidney Problems
		☐	☐ Chronic Stress	☐	☐ Gas Pain & Bloating
Lumbar, Sacrum & Pelvis	• Lower G.I. (Absorption & Motility) • Gut-Immune System • Major Hormonal Control	☐	☐ Constipation	☐	☐ Sciatica & Radiating Pain
		☐	☐ Crohn's, Colitis & IBS	☐	☐ Lumbopelvic / SI Joint Pain
		☐	☐ Diarrhea	☐	☐ Hamstring Tightness
		☐	☐ Bed-wetting	☐	☐ Disc Degeneration
		☐	☐ Bladder & Urination Issues	☐	☐ Leg Weakness & Cramps
		☐	☐ Cramps & Menstrual Issues	☐	☐ Poor Circulation & Cold Feet
		☐	☐ Cysts & Endometriosis	☐	☐ Knee, Ankle & Foot Pain
		☐	☐ Infertility	☐	☐ Weak Ankles & Arches
		☐	☐ Impotency	☐	☐ Lower Back Pain
		☐	☐ Hemorrhoids	☐	☐ Gluten & Casein Intolerance

Patient Name: _____ Date: / /

Automated Text Reminder Consent

Your health is important to us. To help provide you with the best possible care, we send automated text appointment reminders to our patients with the upcoming date and time.

I, _____, give Maple Lake Chiropractic permission to send out text

(Print Name)

reminders for all my future appointments unless otherwise stated.

_____ _____

Signature Date

Patient's Cell Phone Number: _____

We look forward to providing better and more convenient communications with you via messaging. Our goal is to provide you with the tools to keep your care on track. Thank you!

Informed Consent

We encourage and support a **shared decision-making process** between us regarding your health needs. As a part of that process, you have a right to be informed about the condition of your health and the recommended care and treatment to be provided to you so that you can make the decision whether to undergo such care with full knowledge of the known risks. This information is intended to make you better informed in order that you can knowledgably give or withhold your consent.

Chiropractic is based on science which concerns itself with the relationship between structures and function, and how this relationship can affect the restoration and preservation of health.

Adjustments are made by chiropractors to correct or reduce spinal and extremity joint subluxations. **Vertebral subluxation** is a disturbance to the nervous system and is a condition where one or more vertebra in the spine is misaligned and/or does not move properly causing interference and/or irritation to the nervous system. The primary goal in chiropractic care is the removal and/or reduction of nerve interference caused by vertebral subluxation.

A **chiropractic examination** will be performed which may include spinal and physical examination, orthopedic and neurological testing, palpation, specialized instrumentation, radiological examination, and laboratory testing.

The **chiropractic adjustment** is the application of a precise movement and/or force into the spine to reduce or correct vertebral subluxation(s). There are several different methods or techniques by which the chiropractic adjustment is delivered but are typically delivered by hand. Some may require the use of an instrument or other specialized equipment. In addition, physiotherapy or rehabilitative procedures may be included in the management protocol. Among other things, chiropractic care may reduce pain, increase mobility, and improve quality of life.

Risks associated with chiropractic treatment may include soreness, musculoskeletal sprain/strain, or fracture. Risks associated with physiotherapy may include allergic reactions or muscle and joint pain. In addition, there are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence do not establish a cause-and-effect relationship between chiropractic treatment and the occurrence of stroke, rather, recent studies indicate that patients may be consulting with MDs and DCs when they are in the early stages of a stroke. In essence, there is a stroke already in process. However, you are being informed of this reported association because a stroke may cause serious neurological impairment.

I have been informed of the nature and purpose of chiropractic care, the possible consequences of care, and the risks of care, including that care may not accomplish the desired objective. Reasonable alternative treatments have been explained, including the risks, consequences and probable effectiveness of each. I have been advised of the possible consequences if no care is received. I acknowledge that no guarantees have been made to me concerning the results of care and treatment.

I HAVE READ THE ABOVE PARAGRAPH. I UNDERSTAND THE INFOMRATION PROVIDED. ALL QUESTIONS I HAVE ABOUT THIS INFORMATION HAVE BEEN ANSWERED TO MY SATISFACTION. HAVING THIS KNOWLEDGE, I KNOWINGLY AUTHORIZE, MAPLE LAKE CHIROPRACTIC TO PROCEDD WITH CHIROPRACTIC CARE AND TREATMENT.

DATED _____

_____ _____

Patient's Signature Doctor's Signature

Parental Consent for Minor Patient

Patient Name: _____

Patient Age: _____DOB: _____

Printed Name of person legally authorized to sign for:

Name: _____

Signature: _____

Relationship to Patient: _____

In addition, by signing below, I give permission for the above-named minor patient to be managed by the doctor even when I am not present to observe such care.

Printed name of person legally authorized to sign for:

Name: _____

Signature: _____

Relationship to Patient: _____

MAPLE LAKE CHIROPRACTIC

NOTICE OF PRIVACY PRACITCES FOR PROTECTED HEALTH INFORMATION

Maple Lake Chiropractic provides chiropractic services to you as a patient. We receive and maintain your medical information while providing these services to you. When doing so, MLC is required by law to maintain the privacy of your health information and to provide you with this notice of our legal duties and privacy practices with respect to your health information. MLC will follow the terms of this notice. The effective date of this Notice is September 23, 2013. We must follow the terms of this Notice until it is replaced. We reserve the right to change the terms of this Notice at any time. If we make substantive changes to this Notice, we will revise it and send a new Notice to all subscribers covered by us at that time. We reserve the right to make the new changes apply to all your medical information maintained by us before and after the effective date of the new notice. Generally, federal privacy laws regulate how we may use and disclose your health information. In some circumstances, however, we may be required to follow Michigan state law. In either event, we will comply with the appropriate law to protect your health information.

WAYS WE MAY USE OR DISCLOSE YOUR HEALTH INFORMATION WITHOUT YOUR PERMISSION

We must have your written authorization to use and disclose your health information, except for the following uses and disclosures. To You or Your Personal Representative: We may release your health information to you or to your personal representative (someone who has the legal right to act for you). For Treatment: We may use or disclose health information about you for the purpose of helping you get the services you need. For example, we may disclose your health information to health care providers in connection with disease management programs. For Payment: We may use or disclose your health information for our payment-related activities and those of health care providers and other health plans, including, for example: submitting claims to a health insurance company; determining your eligibility for benefits. For Health Care Operations: We may use and disclose your health information in order to support our business activities, including, for example: to conduct quality assessment and improvement activities; to prevent, detect and investigate fraud and abuse; to communicate with you about treatment alternatives or other health-related benefits and services. We may use or disclose parts of your health information to offer you information that may be of interest to you. For example, we may use your name and address to send you newsletters or other information about our activities. We may also disclose your health information to other providers and health plans that have a relationship with you for certain health care operations. For example, we may disclose your health information for their quality assessment and improvement activities or for health care fraud and abuse detection. To Others Involved in Your Care. We may under certain circumstances disclose to a member of your family, a relative, a close friend or any other person you identify, the health information directly relevant to that person's involvement in your health care or payment for health care. For example, we may discuss a your treatments with you in the presence of a friend or relative, unless you object. As required by law. We will use and disclose your health information if we are required to do so by law. For example, we will use and disclose your health information in responding to court and administrative orders and subpoenas, and to comply with workers' compensation or other similar laws. We will disclose your health information when required by the Secretary of the U.S. Department of Health and Human Services. For Health Oversight Activities. We may use and disclose your health information for health oversight activities such as governmental audits and fraud and abuse investigations. For Matters in the Public Interest. We may use and disclose your health information without your written permission for matters in the public interest, including, for example: public health and safety activities, including disease and vital statistic reporting and Food and Drug Administration oversight, to report victims of abuse, neglect, or domestic violence to government authorities, including a social service or protective service agency. To Business Associates. We may release your health information to the business associates we hire to assist us. Each business associate must agree in writing to ensure the continuing confidentiality and security of your medical information.

USES AND DISCLOSURES OF HEALTH INFORMATION BASED UPON YOUR WRITTEN AUTHORIZATION

If none of the above reasons apply, then we must get your written authorization to use or disclose your health information. Once you give us authorization to release your health information, we cannot guarantee that the person to whom the information is provided will not disclose the information. You may take back or "revoke" your written authorization, except if we have already acted based on your authorization. Also, you may not revoke your authorization if it was obtained as a

condition for obtaining insurance coverage and other law provides an insurer with the right to contest a claim under the insurance policy. To revoke an authorization, or to obtain an authorization form, call 269-655-2100.

YOUR RIGHTS

You have the right to inspect and copy your Health Information. This means you may inspect and obtain a paper or electronic copy of the health information that we keep in our records for as long as we maintain those records. You must make this request in writing. Under certain circumstances, we may deny you access to your health information, for instance, if part of certain psychotherapy notes, or if collected for use in court or at hearings. In such cases, you may have the right to have our decision reviewed. Please contact our Customer Service Department if you have questions about seeing or copying your health information. You have the right to amend your Health Information. If you feel that the health information we have about you is incorrect or incomplete, you can make a written request to us to amend that information. We can deny your request for certain limited reasons, but we must give you a written reason for our denial. You have the right to an accounting of disclosures we have made of your Health Information. Upon written request to us, you have the right to receive a list of our disclosures of your health information, except when you have authorized those disclosures or if the releases are made for treatment, payment or health care operations. This right is limited to six years of information, starting from the date you make the request. You have the right to request confidential communications of your Heath Information. You have the right to request that we communicate with you about health information in a certain way or at a certain location. Your request must be in writing. For example, you can ask that we only contact you at home or only at a certain address or only by mail. You have the right to request restrictions on how we use or disclose your Health Information. You may request that we restrict how we use or disclose your health information. We do not have to agree to your request except for requests for a restriction on disclosure to another health plan if the disclosure is for payment or health care operation, is not required by law and pertains only to a health care item or service which has been paid for in full. You may also opt out of communication relating to fundraising (information on how to opt out should be included on each fundraising communication). You have the right to restrict certain disclosures from your Health Information. Under circumstances where you or someone you your behalf pays in cash or cash equivalents (out of pocket) for the entire services you received, you may restrict disclosures of your Health Information to health plans. Right to receive notice of a breach. If your unencrypted information is impermissibly disclosed, you have a right to receive notice of that breach unless, based on an adequate risk assessment, it is determined that the probability is low that your health information has been compromised. How to Use Your Rights under this Notice. If you want to use your rights under this Notice, you may call us or write to us. In some cases, we may charge you a nominal, cost-based fee to carry out your request.

COMPLAINTS

You may complain to Maple Lake Chiropractic or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by calling 269-655-2100. We will not retaliate against you for filing a complaint. To complain to the federal government, you may write to: Region V, Office for Civil Rights, U.S. Department of Health and Human Services, 233 N. Michigan Ave. Ste. 240, Chicago, Illinois 60601. Voicemail: 312-866-2359, Fax, 312-866-1807, TDD: 312-353-1807. There will be no negative consequences to you for filing a complaint to the federal government.

All questions concerning this notice or requests made to it should be addressed to Maple Lake Chiropractic 109 W Michigan Ave, Paw Paw, MI 49079

I do hereby acknowledge receipt of a copy of the Notice of Privacy Practices, Policies, and Procedures

Patient Name	**Signature**	**Date**
Name Of Personal Rep/Guardian	**Signature**	**Date**