PEDIATRIC QUESTIONNAIRE

Name: (Last, First MI)______________________________________ **Today's Date:** ___________

PEDIATRIC REVIEW OF SYSTEMS

Pediatric:
- ☐ ADHD
- ☐ Allergies/Asthma
- ☐ Autism
- ☐ Back/Neck Pain
- ☐ Bed Wetting
- ☐ Behavioral issues
- ☐ Chronic Earaches
- ☐ Colic
- ☐ Constipation
- ☐ Growing Pains
- ☐ Nightmares
- ☐ Reflux
- ☐ *None in this Category*

Childhood Diseases:
- ☐ Chicken Pox: Age ____
- ☐ Measles: Age ____
- ☐ Meningitis: Age ____
- ☐ Mumps: Age ____
- ☐ Rubella: Age ____
- ☐ Tuberculosis: Age ____
- ☐ Whooping Cough: Age ____
- ☐ Other:__________ Age ____
- ☐ *None in this Category*

Has your child been vaccinated?
☐ **No** ☐ **Yes**
*(Any Adverse Reactions? – Describe:)*_____________
____

INFANTS AND NEWBORNS

Prenatal History:

Location of Birth: ☐ Home ☐ Birthing Center ☐ Hospital

Birth Weight: _________ **Birth Length:** _________ **Full Term?** ☐ **No** ☐ **Yes** *(Describe)*__________________________

Complications during pregnancy? ☐ **No** ☐ **Yes** *(Describe)* ______________________________________

Medications during pregnancy or delivery? ☐ **No** ☐ **Yes** *(List)* ______________________________________

Cigarette / Alcohol / Drugs during pregnancy? ☐ **No** ☐ **Yes** *(List)* ______________________________________

Birth Interventions? ☐ **No** ☐ **Yes** ☐ Forceps ☐ Vacuum ☐ Caesarian ☐ Other: ______________________

Complications during delivery? ☐ **No** ☐ **Yes** *(Describe)* ______________________________________

Feeding History:

Breast fed? ☐ **No** ☐**Yes** *(How Long?)* ______ **Formula fed?** ☐ **No** ☐**Yes** *(How Long?)* ______ *(Type?)* ______________________

Introduced to cereal at ____ months old. **Solids at____ months old.** **Cow's milk at____ months old.**

Food / Juice allergies or intolerances? ☐ **No** ☐ **Yes** *(Describe)* ______________________________________

Developmental History:

Sleep *(Hours per Night?)* _______ **Problems Sleeping?** *(Describe)* ___________ ______________________________________

CONSENT FOR TREATMENT OF A MINOR

I hereby authorize: ________________________________ *(Doctor's Name)* and whomever he or she may designate as assistants to administer examinations and chiropractic care as deemed necessary to: ________________________________ *(Minor Patient's Name)*

____
Printed Name of Parent or Guardian

____ ________
Signature of Parent or Guardian Date

____ ________
Witness Date

Patient No: ___________

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Introduction Patient Case History

Today's Date: ____/____/_____

PATIENT INFORMATION

Name: *(First MI Last)* ______________________________ **Preferred Name:** ______________

Address: ______________________ **City:** ____________ **State:** ______ **Zip:** ____________

Date of Birth: __________ **Gender:** ☐ Male ☐ Female **Social Security #:**______________

Home: ____________ **Mobile:** ____________ **Work:** ____________

Email: ______________________________

Preferred Method of Contact: ☐ Text ☐ Email ☐ Phone - *Home, Mobile, or Work* ☐ Other: __________

***Referred By:** *(Name)* ______________________

☐ Family ☐ Friend ☐ Co-Worker ☐ Doctor ☐ Other: __________

Race & Ethnicity: *(Choose up to 2)*

- ☐ African American or Black
- ☐ American Indian or Alaskan Native
- ☐ Asian
- ☐ Hispanic or Latino
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White
- ☐ Decline

Preferred Language:

- ☐ English
- ☐ Spanish
- ☐ Other: ____________
- ☐ Decline

EMERGENCY CONTACT INFORMATION

Name: *(First MI Last)* ______________________

Home: ____________ **Mobile:** ____________

Relationship:

☐ Child ☐ Parent ☐ Spouse ☐ Other: ____________

Primary Care Physician: ______________________

Doctor's Phone: ______________________

FINANCIAL INFORMATION

Is today's visit the result of an accident?

☐ No ☐ Auto ☐ Work ☐ Other: __________

Will we be working with insurance? ☐ No ☐ Yes *(Details)*

Primary: ________________ *ID#:* ____________

Secondary: ________________ *ID#:* ____________

Where would you like statements sent?

☐ Self ☐ Other *(Details below)*

Name: ______________________________

Address: ______________________________

Phone: ____________ *Email:* ________________

It is Usual and Customary to Pay for Services as Rendered Unless Otherwise Arranged

Account No: __________

HISTORY OF PRESENT ILLNESS

HISTORY OF PRESENT ILLNESS *(Please describe)*

Major Complaint: ______________________________________
____
____

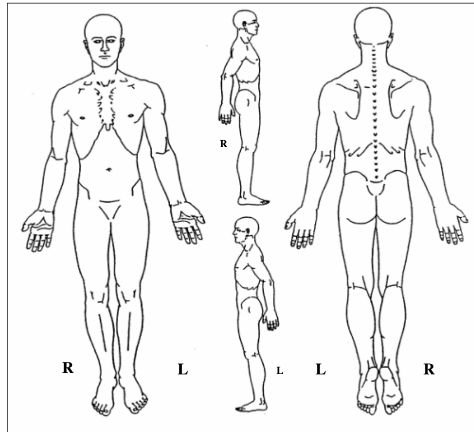
Secondary Complaints: ______________________________________
____
____

When did it start? ____/____/_____ **What happened?** ______________________________________
____

Which daily activities are being affected by this condition? ______________________________________
____

MAJOR COMPLAINT

Location of Symptoms and Radiation



P __ Pain
N __ Numb
S __ Spasm
T__ Tender
H__ Hypoesthesia

Grade Intensity/Severity:

- ☐ None (0/10)
- ☐ Mild (1-2/10)
- ☐ Mild-Moderate (2-4/10)
- ☐ Moderate (4-6/10)
- ☐ Moderate-Severe (6-8/10)
- ☐ Severe (8-10/10)

Frequency:

- ☐ Off & On
- ☐ Constant

Quality:

- ☐ Sharp
- ☐ Stabbing
- ☐ Burning
- ☐ Achy
- ☐ Dull
- ☐ Stiff & Sore
- ☐ Other: ________________

Does it radiate?

☐ No ☐ Yes *(Please indicate on drawing)*

Improves with:

- ☐ Ice
- ☐ Heat
- ☐ Movement
- ☐ Stretching
- ☐ OTC Medications: ______________
- ☐ Other: ____________________

Worsens with:

- ☐ Sitting
- ☐ Standing/Walking
- ☐ Lying Down/Sleeping
- ☐ Overuse/Lifting
- ☐ Other: ______________________

Previous Treatment:

- ☐ None
- ☐ Chiropractor ________________
- ☐ Medical Doctor ________________
- ☐ Physical Therapy ______________
- ☐ ER/Urgent Care ______________
- ☐ Orthopedic ________________
- ☐ Other: ________________

Previous Diagnostic Testing:

- ☐ None
- ☐ X-rays ________________
- ☐ MRI ________________
- ☐ CT ________________
- ☐ Other: ________________

Women:** ***Are you pregnant?

☐ No *Last Menstrual Period:* ___/___/____

☐ Yes *Due date:* ___/___/____

Present Illness Comments:

____
____
____
____
____
____

Prescription Medications & Supplements: ☐ None

☐ Yes *(List – Name, dosage, frequency)* ______________________________________
____
____
____
____
____

Allergies to Medications: ☐ No known drug allergies

☐ Yes *(List - Name and reaction)*______________________________________
____
____
____
____
____

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SEAMLESS™ EHR

Revision Date 03/14/2017

Past, Family, and Social History

Past Medical History

Have you *ever* had any of the following? *(Please select all that apply and use comments to elaborate.)*

Illnesses:
- ☐ Asthma
- ☐ Autoimmune Disorder (*Type*) ________
- ☐ Blood Clots
- ☐ Cancer (*Type*) ____________________
- ☐ CVA/TIA (stroke)
- ☐ Diabetes
- ☐ Migraine Headaches
- ☐ Osteoporosis
- ☐ Other: __________________________

____

____

Injuries:
- ☐ Back Injury
- ☐ Broken Bones
- ☐ Head Injury
- ☐ Neck Injury
- ☐ Falls
- ☐ Other: __________________________

Hospitalizations: *(Non-surgical with Date)*

____

____

Surgeries: *(If yes, provide type & surgery date)*
- ☐ Cancer __________________________
- ☐ Orthopedic
  - Shoulder – R / L ____________
  - Elbow/Forearm – R / L ____________
  - Wrist/Hand – R / L ____________
  - Hip – R / L ____________
  - Knee – R / L ____________
  - Ankle/Foot – R / L ____________
- ☐ Spinal Surgery
  - Neck: ________________________
  - Back: ________________________
- ☐ Other: ________________________

____

____

Medical History Comments:

____

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____

Family History *(Please mark **X** to all that apply and use comments to elaborate.)*

☐ Unknown ☐ Unremarkable

	Mother	Father	Sibling1	Sibling2	Sibling3	Child1	Child2	Child3
Gender	F	M						
Age at death *(if Deceased)*								
Aneurysms								
CVA (Stroke)								
Cancer								
Diabetes								
Heart Disease								
Hypertension								
Other Family History								

Family History Comments:

____

____

____

____

____

____

____

____

____

____

____

Social and Occupational History

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Other

Children: ☐ None ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ Other:________________

Student Status: ☐ Full Student ☐ Part Student ☐ Non-Student

Highest level of Education: ☐ High School ☐ College Grad.

☐ Post Grad. ☐ Other: ________________________________

Employed: ☐ No ☐ Yes (*Occupation*) ______________________

Dominant Hand: ☐ Right ☐ Left ☐ Ambidextrous

Smoking/Tobacco Use: *If current smoker, amount =* ___________

☐ Every Day ☐ Some Days ☐ Former ☐ Never

Alcohol Use:

☐ Every Day ☐ Weekly ☐ Occasionally ☐ Never

Caffeine Use:

☐ Coffee ☐ Tea ☐ Energy Drinks ☐ Soda ☐ Never

Exercise frequency:

☐ Daily ☐ 3-4xs/week ☐ 2-3xs/week ☐ Rarely ☐ Never

Social History Comments: ________________________________

____

____

____

____

____

____

____

REVIEW OF SYSTEMS

Many of the following conditions respond to chiropractic treatment.

Are you *currently* experiencing any of these symptoms? *(Please select all that apply and use comments to elaborate.)*

Constitutional: *(General)*
- ☐ Fever
- ☐ Fatigue
- ☐ Other: ______________________
- ☐ *None in this Category*

Musculoskeletal:
- ☐ Joint Pain/Stiffness/Swelling
- ☐ Muscle Pain/Stiffness/Spasms
- ☐ Broken Bones_________________
- ☐ Other: ______________________
- ☐ *None in this Category*

Neurological:
- ☐ Dizziness or Lightheaded
- ☐ Convulsions or Seizures
- ☐ Tremors
- ☐ Other: ______________________
- ☐ *None in this Category*

Psychiatric: *(Mind/Stress)*
- ☐ Nervousness/Anxiety
- ☐ Depression
- ☐ Sleep Problems
- ☐ Memory Loss or Confusion
- ☐ Other: ______________________
- ☐ *None in this Category*

Genitourinary:
- ☐ Frequent or Painful Urination
- ☐ Blood in Urine
- ☐ Incontinence or Bed Wetting
- ☐ Painful or Irregular Periods
- ☐ Other: ______________________
- ☐ *None in this Category*

Gastrointestinal:
- ☐ Loss of Appetite
- ☐ Blood in Stool or Black Stool
- ☐ Nausea or Vomiting
- ☐ Abdominal Pain
- ☐ Frequent Diarrhea
- ☐ Constipation
- ☐ Other: ______________________
- ☐ *None in this Category*

Cardiovascular & Heart:
- ☐ Chest Pains/Tightness
- ☐ Rapid or Heartbeat Changes
- ☐ Swelling of Hands, Ankles, or Feet
- ☐ Other: ______________________
- ☐ *None in this Category*

Respiratory:
- ☐ Difficulty Breathing
- ☐ Cough
- ☐ Other: _________________
- ☐ *None in this Category*

Eyes & Vision:
- ☐ Eye Pain
- ☐ Blurred or Double Vision
- ☐ Sensitivity to Light
- ☐ Other: ______________________
- ☐ *None in this Category*

Head, Ears, Nose, & Mouth/Throat:
- ☐ Frequent or Recurrent Headaches
- ☐ Ear - Ache/Ringing/Drainage
- ☐ Hearing Loss
- ☐ Sensitivity to Loud Noises
- ☐ Sinus Problems
- ☐ Sore Throat
- ☐ Other: ______________________
- ☐ *None in this Category*

Endocrine:
- ☐ Infertility
- ☐ Recent Weight Change
- ☐ Eating Disorder
- ☐ Other: ______________________
- ☐ *None in this Category*

Hematologic & Lymphatic:
- ☐ Excessive Thirst or Urination
- ☐ Cold Extremities
- ☐ Swollen Glands
- ☐ Other: ______________________
- ☐ *None in this Category*

Integumentary: *(Skin, Nails, & Breasts)*
- ☐ Rash or Itching
- ☐ Change in Skin, Hair, or Nails
- ☐ Non-healing Sores or Lesions
- ☐ Change of Appearance of a Mole
- ☐ Breast Pain, Lump, or Discharge
- ☐ Other: ______________________
- ☐ *None in this Category*

Allergic/Immunologic:
- ☐ Food Allergies
- ☐ Environmental Allergies
- ☐ Other: ______________________
- ☐ *None in this Category*

Review of Systems Comments:

____

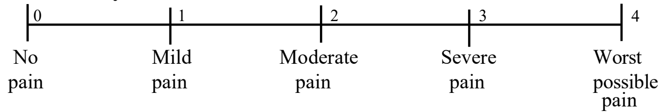
I have answered these questions to the best of my knowledge and certify them to be true and correct.

Patient or Guardian Signature ____ Date______________________

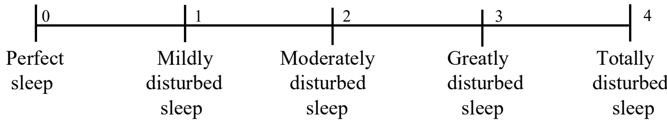
Functional Rating Index

In order to properly assess your condition, we must understand how much your problems have affected your ability to manage everyday activities.
For each item below, **please circle the <u>WHOLE NUMBER</u> which most closely describes your condition.**

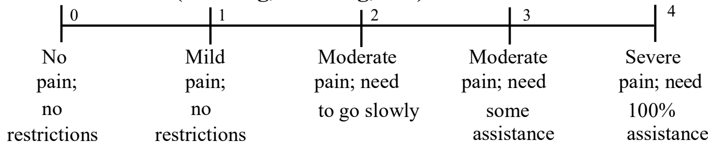
1. Pain Intensity



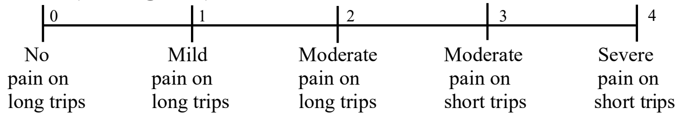
2. Sleeping



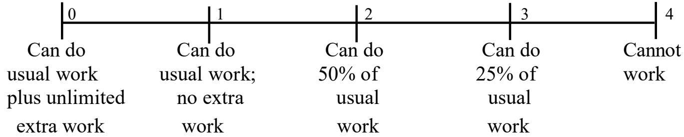
3. Personal Care (washing, dressing, etc.)



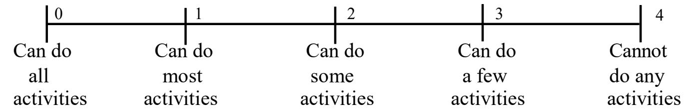
4. Travel (driving, etc.)



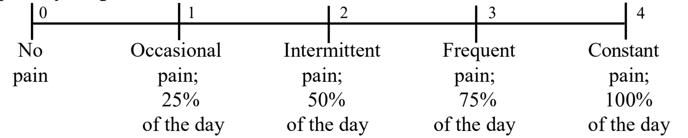
5. Work



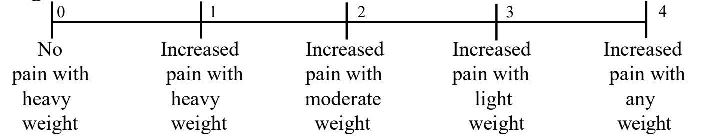
6. Recreation



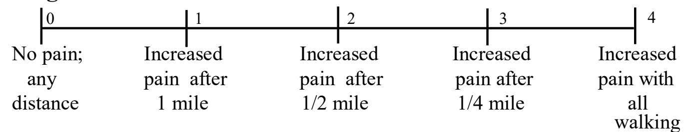
7. Frequency of pain



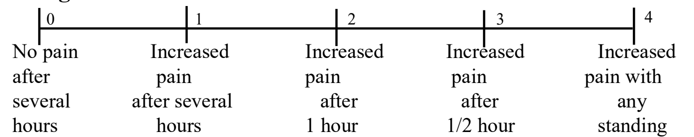
8. Lifting



9. Walking



10. Standing



Name ____
PRINTED

Total Score _________

____
Signature

____
Date

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Dr. Curtis Begin • 1550 Norwood Dr Ste 209, Hurst, TX 76054 • Phone: (817) 514-1908 • Fax: (817) 514-1941
www.drcurtisbegin.com

Patient Name: ____ DOB: __________________ Date: __________________

Before this office begins any health care operations we require you to read and sign this form stating that you understand the below item. If you refuse to sign this form the doctor reserves the right to refuse care.

AUTHORIZATION: By signing below you authorized this office/provider to complete a consultation and examination on the above.

AUTHORIZATION FOR X-RAY WITH RELEASE: By signing below you have declared, to the best of your knowledge, that there is no chance you are pregnant at this time. By signing below you have declared that you have no known limitations that would be contraindicated for an x-ray evaluation. By signing below you consent to the taking of x-rays if there is a determined need.

CONSENT FOR CHIROPRACTIC SERVICES: I have been made aware: The process of delivering a "Chiropractic Adjustment (manipulation)" may be performed manually or with an instrument to the vertebra(e) of the spine and/or associated structures (legs, arms etc.), often resulting in an audible pop or click sound. As an addition to the Chiropractic Adjustment "Supportive Therapies and/or Procedures" may be applied by the chiropractor or by staff under the chiropractor's direction or supervision incorporating the use of intersegmental traction. That on occasion some temporary soreness and/or stiffness may occur; less frequently aggravation of presenting symptoms or initiation of new symptoms; rarely bruising, swelling, even more rare separation/fracture; and extremely rare, nerve or vascular injury may occur in conjunction with the process of a Chiropractic Adjustment. That the chiropractor has made no guarantee of a positive outcome from treatment. I have been afforded ample opportunity for questions and answers. I **consent** to the performance of the diagnostic and therapeutic procedures performed by the doctor and or staff under the direction and supervision of the office chiropractor(s) involved in my case. I **consent** to the performance of other diagnostic and therapeutic procedures in the future that may be deemed reasonable and necessary by the doctor and or staff under the direction and supervision of the office chiropractor(s) involved in my case.

ACKNOWLEDGMENT OF ASSIGNMENT OF BENEFITS: By signing below you have acknowledged that you are fully responsible for all services rendered. By signing below you furthered acknowledge understanding that your health and accident insurance information policies are an arraignment between you and your carrier, and that you may be required to pay some or all of the fees charged to your account. By signing below you hereby assign benefits to be paid directly to this office/provider by your third-party payer, e.g. insurance company, attorneys, etc. By signing below you agree that this is a non-rescindable agreement and failure to fulfill this obligation will be considered a breach of contract between you and this office.

CMS-1500 HEALTH INSURANCE CLAIM FORM: By signing below you acknowledge and agree that the CMS-1500 Health Insurance Claim Form Box 12 and Box 13 will state "Signature on File". Box 12 Reads as follows: "PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below." Box 13 Reads as follows: "INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below."

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES: We are very concerned with protecting your personnel health information. There may be times our office may need to contact you regarding office matters. By signing below you have authorized this office to contact you for office related matters in the following manner: phone-work-home or mobile, e-mail and regular mail. Messages may be left on an answering device/voicemail, or with the person answering your phone-home-work-mobile. Also in accordance with the Health Insurance Portability and Accountability act of 1996 (HIPAA), updated September 23, 2013, this office is obliges to supply you with a copy of the office privacy policies and procedures upon request. This document outlines the use and limitations of the disclosure of your personal health information and your rights as a patient. By signing below you have acknowledged that you have been offered a copy of this document.

CLINICAL SUMMARY REPORT (CCR): I understand that a clinical summary report is created after each visit for the purpose of EHR and is available for my review. At this time, I am asking New Leaf Chiropractic to save these electronically for me and not print them out after each visit. I understand that upon request these reports are available to be printed or emailed to me for review.

ACKNOWLEDGEMENT OF TREATMENT PLAN: By signing below I acknowledge that, if accepted for care, I may be presented with a chiropractic treatment plan resulting in one or more of the following services: chiropractic adjustments, examinations, and supportive therapies and procedures.

ACKNOWLEDGEMENT: By signing below you have acknowledge that you understand and agree with the policies and procedures outlined in this TERMS of ACCEPTANCE form. By signing below you acknowledge and certify that all the information given to the office/provider in the INTAKE forms are a true and accurate to the best of you knowledge.

CONSENT FOR TREATMENT OF MINOR: I, the parent or legal guardian of ___________________________________ (minor child's name), hereby give my permission to New Leaf Chiropractic to treat said child.

PRIMARY CARE PHYSICIAN RELEASE: To improve the quality and continuity of your care, do we have your permission to send our notes and reports to your Primary Care Physician (PCP)? ❑ Yes ❑ No

Patient or Parent (Legal Guardian) Signature: ____

AUTHORIZATION TO SEND/RECEIVE APPOINTMENT AND MEDICAL INFORMATION BY EMAIL/TEXT

This practice utilizes email and/or text messaging to communicate with patients.

RISKS: Transmitting information by email/text has a number of risks that patients should consider before using. These include, but are not limited to, the following: Email/text can be circulated, forwarded, and stored in numerous paper and electronic files. Can be immediately broadcast worldwide and be received by many intended and unintended recipients. Can easily misaddress an email or text. Are easier to falsify than handwritten or signed documents. Can be intercepted, altered, forwarded, or used without authorization or detection. Can be used to introduce viruses into computer systems. Can be used as evidence in court. Backup copies of email/text may exist even after the sender or the recipient has deleted his or her copy. Employers and on-line services have a right to archive and inspect emails/texts transmitted through their systems.

CONDITIONS: Because of the Risks outlined above, the practice cannot guarantee the security and confidentiality of email/text communication, and will not be liable for improper use and/or disclosure of confidential information that is not caused by the practice's intentional misconduct. Thus, patients must consent to the use of email/text for patient information. Consent to the use of email/text includes agreement with the following conditions:

1. All emails/texts to or from the patient concerning diagnosis or treatment will be saved as part of the medical record. Because they are a part of the medical record, other individuals authorized to access the medical record, such as staff and billing personnel, will have access to those emails/texts.
2. Although the practice will endeavor to read and respond promptly to an email/text from the patient, the practice cannot guarantee that any particular email/text will be read and responded to within any particular period of time. Thus, the patient shall not use email/text for medical emergencies or other time-sensitive matters.
3. If the patient's email/text requires or invites a response from the practice, and the patient has not received a response within a reasonable time period, it is the patient's responsibility to follow up to determine whether the intended recipient received the email/text and when the recipient will respond.
4. The patient should not use email/text for communication regarding sensitive medical information, such as information regarding sexually transmitted diseases, AIDS/HIV, mental health, developmental disability, or substance abuse.
5. The patient is responsible for informing the practice of any types of information the patient does not want to be sent by email/text, in addition to those set out in the preceding paragraph.
6. The patient is responsible for protecting his/her password or other means of access to email/text.
7. The practice is not liable for breaches of confidentiality caused by the patient or any third party.
8. The practice shall not engage in email/text communication that is unlawful, such as unlawfully practicing medicine across state lines.
9. It is the patient's responsibility to follow up and/or schedule an appointment if warranted.

INSTRUCTIONS: To communicate by email/text, the patient shall:

1. Limit or avoid use of his/her employer's computer.
2. Inform the practice of changes in his/her email address or text number.
3. Put the patient's name in the body of the email/text.
4. Inform the practice that the patient received an email/text from the practice.
5. Take precautions to preserve the confidentiality of emails/texts, such as using screen savers and safeguarding his/her computer password.
6. Withdraw consent only by email or written communication to the practice.
7. Contact the doctor or staff with any privacy concerns before communicating with the practice via email or text message.

PATIENT ACKNOWLEDGMENT AND AGREEMENT

I acknowledge that I have read and fully understand the information the practice has provided me regarding the risks of using email and text messaging. I understand the risks associated with the communication of email and text between the practice and me, and consent to the conditions outlined in this document. In addition, I agree to the instructions outlined above, as well as any other instructions that the practice may impose regarding email or text message communications.

______________________________ *Phone number to be used for appointment text*

______________________________ *Email address authorized to be used for sending medical records*

Patient Name	*Patient Signature*	*Date*
Patient/Guardian Name	*Patient/Guardian Signature*	*Date*

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