First Choice Family chiropractic Rehab & Massage

Pediatric Patient Questionnaire

Today's Date: / /

CONFIDENTIAL PATIENT INFORMATION

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

Street Address: City: State: Zip:

Cell Phone: - - Home Phone: - - Work Phone: - -

Email: Child's SS#: - - Birthdate: / / Age:

How did you hear about us? Height: ft. in. Weight lbs

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 speciality:

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

CURRENT HEALTH CONDITIONS

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

When did this condition first begin? How did the problem start? ☐Suddenly ☐Gradually ☐Post-Injury

Has your child ever received care or this condition before? ☐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:	What would you like to gain from chiropractic care?
1.	☐ Resolve existing condition
2.	☐ Overall wellness
3.	☐ Both

Have you ever visited a chiropractor? ☐Yes ☐ No If yes, what is their name?

What is their specialty? ☐Pain Relief ☐Physical Therapy & Rehab ☐Nutritional ☐Subluxation-based ☐Other:

PREGNANCY & FERTILITY HISTORY

Please tell us about your pregnancy

Any fertility issues?	☐ Yes	☐ No	Yes yes, please explain:
Did mother smoke?	☐ Yes	☐ No	If yes, how many per week?
Did mother drink?	☐ Yes	☐ No	If yes, how many per week?
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 notable 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's was your child born?

Child's birth was: ☐At home ☐At a birthing center ☐At a hospital ☐Other: Doctor/Obstetrician's name:

Please check any applicable interventions or complications:

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

Child's birth weight: lbs. oz. Child's birth height: in. APGAR score at birth: APGAR score after 5 minutes:

GROWTH & DEVELOPMENT HISTORY

Is/was your child breasfed? ☐Yes ☐No If yes, how long? Difficulty with breastfeeding? ☐Yes ☐No

Did they ever use formula? ☐Yes ☐No If yes, at what age? What brand/type?

Did/does your child ever 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 bank 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 allergices,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 vaccination 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 a 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: _____/_____/_____

Dr. April Stratford | First Choice Family Chiropractic
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478-272-1800
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Patient Review of Systems

Patient Name: _____ Date: _____/_____/_____

REGIONS	FUNCTIONS	PAST	PRESENT	SYMPTOMS	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 & Siezures
		☐	☐	Ear & Sinus Infections	☐	☐	Sensory & Spectrum
		☐	☐	Allergies & Congestion	☐	☐	ADD / ADHD
		☐	☐	Immune Deficiency	☐	☐	Focus & Memory Issues
		☐	☐	Headaches & Migranes	☐	☐	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
		☐	☐	Chron'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

Parent/Guardian Signature: _____ Date: _____/_____/_____

First Choice Family Chiropractic Financial Policy

Our recommendations are based on a desire to see you get well and stay well. Chiropractic care is covered under many insurance plans. Most of our patients that have health or accident insurance will fall under one of the plans discussed in this policy. Regardless of your coverage, we'll suggest the chiropractic care we think you need. We ask that you read and understand our policy as it applies to your particular situation.

PATIENTS WITHOUT INSURANCE

We request that 100% of the first visit be paid at the time of the visit. On other visits, payment may be made at the end of the week if you sign a credit guarantee form. We are happy to accept your check, MasterCard or Visa.

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. When possible, we will call to verify benefits on your insurance; however, the benefits quoted to us by your insurance company are 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 services rendered are charged to you directly and you are personally responsible for payment of any non-covered services, deductibles, or co-pays. You may also pay the full amount due each day thereby qualifying for our Time of Service Reduction in fees. You may then submit the bill to your insurance carrier for reimbursement.

"ON THE JOB" INJURY (WORKERS COMPENSATION)

If you are injured on the job, your care should be paid for under your employer's workers compensation insurance. You will need to inform your employer of the accident and obtain the name and address of the carrier of their insurance. If your employer does not provide us with this information, if a settlement has not been made within 3 months, or if you suspend or terminate care, any fees and services are due immediately.

SECONDARY INSURANCE

Please inform us of any secondary insurance you may have. We will assist you if you need help in filing.

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 checks in the mail, please contact us to see if it represents payment of your bill here

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 FIRST CHOICE FAMILY CHIROPRACTIC THAT FEES WILL BE DUE AND PAYABLE IMMEDIATELY ALONG WITH ANY INTEREST FEE, COLLECTION FEE, OR COURT COST USED TO OBTAIN MY DEBT. I UNDERSTAND THAT FIRST CHOICE FAMILY CHIROPRACTIC WILL NOT ALLOW A DEBT GREATER THAN $100. IN THE EVENT I NEED TO MAKE A PAYMENT PLAN I ALSO UNDERSTAND THAT I MUST FIRST DECREASE MY BALANCE TO $100 BEFORE SAID PAYMENT PLAN CAN BE ARRANGED UNLESS I HAVE MADE OTHER ARRANGEMENTS WITH THE BILLING DEPARTMENT. ALL AGREEMENTS MUST BE WRITTEN AND SIGNED BY BOTH PARTIES. ALL PERSONAL INJURY CASES WILL HAVE A 6 MONTH GRACE PERIOD FROM THE DATE OF RELEASE. IF NO PAYMENT HAS BEEN MADE ON MY BEHALF I UNDERSTAND THAT I AM RESPONSIBLE FOR PAYMENT IN FULL AT THE END OF MY GRACE PERIOD ALONG WITH ANY FEES STATED ABOVE USED TO COLLECT THE DEBT.

_____

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

First Choice Family chiropractic Rehab & Massage

INFORMED CONSENT FOR EXAMINATION AND TREATMENT

I (We) hereby consent to the performance of examination and treatment on me or on _____ by the licensed doctors of chiropractic, medical doctors; and/or licensed physical therapists who may be employed by or engaged in practice in this clinic.

I have had an opportunity to discuss with the doctor(s) or other clinic personnel the nature and purpose of the different physical therapy procedures and chiropractic treatment (manipulation/adjustment). I understand that neither chiropractic nor medical treatment is an exact science and that my care may involve judgments based upon facts and information known to the doctor. The doctor uses this judgment to attempt to anticipate or explain risks and complications and an undesirable result does not necessarily indicate an error in judgment. No guarantee for results can be made or expected but rather I wish to rely on the doctor to choose and recommend a best course of treatment based upon facts known that is in my best interests.

I further understand that there are certain degrees of risk associated with chiropractic health care and physical therapy, which includes rarely, but not limited to: fractures, disc injuries, strokes, and strain/sprains and am therefore willing to accept and consent to the risk associated with the care that I am about to receive.

I have read, or the above information has been explained regarding consent. I have had an opportunity to ask questions about my examination and treatment. By signing below, I agree and intend this consent form to cover the procedures prescribed for my condition and for any future conditions for which I seek treatment.

Female Patients: By my signature on this form I do hereby state that to the best of my knowledge, I am not pregnant, nor is pregnancy suspected or confirmed at this particular time.

Date of last menstrual period: _____.

_____ _____

Patient's Name (Printed) Patient's Signature

_____ _____

Date Relationship or authority if not signed by patient

_____

Witness

First Choice Family chiropractic Rehab & Massage

Insurance Information

Insurance Company: _____

Member ID: _____

Group #: _____

If you are not the policy holder for this insurance, please provide the following information.

Policy holder's Name: _____

Policy holder's relation to you: _____

Policy holder's date of birth: _____

Policy holder's social security number: _____ - _____ - _____

Payment is expected at the time of service unless prior arrangements have been made. If you have a co-payment or co-insurance, please be prepared to pay it at each visit.

Assignment & Release

I Certify that I, and/or my dependent(s), have insurance coverage with _____ (Name of insurance company) and assign directly to Dr. April Stratford/Dr. Jeff Stratford all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named doctor may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed for one year from date signed below.

Signature of Patient, Parent, Guardian or Personal Representative:

_____

Print name of Patient, Parent, Guardian or Personal Representative:

_____

Date: _____ Relationship to patient: _____

First Choice Family chiropractic Rehab & Massage

NO SHOW AND CANCELLATION POLICY
$30.00 FEE IF YOU NO SHOW

Cancellation of an appointment
If it is necessary to cancel your scheduled appointment, we ask that you call 24 hours in advance. Appointments are in high demand, and your early cancellation will give another person the possibility to have access to timely medical care.

How to cancel your appointment
To cancel your appointment, please call (478) 272-1800.

No show policy
A “no show” is someone who misses an appointment without cancelling it 24 hours in advance of the scheduled appointment. No shows inconvenience those individuals who need who need access to medical care in a timely manner. Failure to arrive on time to your scheduled appointment will be recorded in your chart as a “no show”. The first time there is a “no show” you will be called and informed of the appointment so that we may reschedule. If there is a second “no show”, a fee of $30.00 will be billed to you. Your insurance company **WILL NOT** pay this. This fee will cover administrative tasks associated with your appointment. This fee must be paid before scheduling any further appointments.

BY SIGNING BELOW I ACKNOWLEDGE RECEIPT AND WILL ABIDE BY THE NO SHOW AND CANCELLATION POLICY.

Signature: _____ Date: _____

Print Name: _____