

NEW PATIENT INFORMATION

Name: (Last) _____ **(First)** _____ **(Middle)** _____ **DOB:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Home #: _____ **Work #:** _____

E-Mail- _____ Would you like to receive our e-mail health bulletin? **YES/NO**

SS#: _____ **Marital Status (S-M-Sep-D-W)** _____ **Sex: (Male/Female)** _____ **Age:** _____

Employer: _____ **Work Title:** _____

Name & Phone # of Relative or Neighbor _____

Name of Spouse _____ **Spouse Employer** _____

Spouse DOB _____ **Spouse Work #** _____ **Spouse SS#** _____

Who is responsible for this account (Patient/Insurance)? _____

Is this case covered by insurance (Blue Cross, Auto Accident Ins., Medicare, etc.) Yes/No

Insurance Carrier: _____ **Phone #:** _____

Policy # _____ **Group #** _____ **Subscriber** _____

Major Complaint (Back Pain, Neck Pain, etc.) _____

Whom may we thank for referring you to our office? _____

(Doctor, Patient, Friend, Relative, Newspaper, Yellow Pages, Internet?)

Is this a result of: **Auto Accident** ___ **Work Injury** ___ **Other** _____

Date of Injury: _____ **Do you have an Attorney (Name)?** _____

Describe Accident: _____

Women Only:

Are you pregnant? Yes/No **Date of last menstrual period:** _____

CONSENT TO CARE

A patient coming to the doctor gives him/her permission and authority to care for the patient in accordance with appropriate tests, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare cases underlying physical defects, deformities or pathologies, may render the patient susceptible for injury. The doctor, of course, will not provide specific healthcare, if he/she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through health care procedures from whatever he/she is suffering from: latent pathological defects, illnesses, or deformities which would otherwise not come to the attention of the physician.

PAYMENT POLICY

I understand that this office will file my insurance claim for me upon request and that any amount paid directly to this office by my insurance company will be credited to my account. However, I clearly understand and agree that I am personally responsible for paying fee's for service (regardless of my insurance coverage) and at any time it can be request that I pay all or part of the balance of my account.

I have read and understand the foregoing.

Patient's Signature _____ **Date** _____

Witness Signature _____ **Date** _____

Initial Child & Adolescent Questionnaire

Your Name: _____ Your Mom: _____
Your Dad: _____

Mainly for Moms:

1. Tell us about your pregnancy;

Did you carry to full term? _____
Describe any complications and when they occurred: _____

2. Tell us about your delivery and birth of this child:

Did you use a midwife? Hospital? Obstetrician? _____
Did you have a C-Section? Were forceps used? _____
Vacuum Extraction? Were you induced? _____
Did you have an Epidural? _____ Was it a difficult birth? _____
What was the baby's **APGAR** Score? at 5 minutes? _____

3. Tell us more:

Did you breastfeed? How long? What formula after? _____
Did you consume alcohol during your pregnancy? How much? _____
Did you smoke? How much? How long? _____
Did you take any medication during your pregnancy? _____ For what? What type? _____
Any exposures to ultrasound? , How many? _____

4. As a baby/toddler, (birth to 4 years), did any of the following occur?

<input type="checkbox"/> Fall from a change table	<input type="checkbox"/> Frequent crying spells
<input type="checkbox"/> Tumble down stairs	<input type="checkbox"/> Frequent fevers
<input type="checkbox"/> Fall out of crib	<input type="checkbox"/> Frequent bouts of diarrhea
<input type="checkbox"/> Involved in car accident	<input type="checkbox"/> Constipation
<input type="checkbox"/> Fall off playground equipment	<input type="checkbox"/> Sleeping problems
<input type="checkbox"/> Play in a Jolly Jumper	<input type="checkbox"/> Frequent colds
<input type="checkbox"/> Frequent ear infections	<input type="checkbox"/> Colic
<input type="checkbox"/> Tonsillitis	<input type="checkbox"/> Did not gain weight
<input type="checkbox"/> Reaction to vaccination	<input type="checkbox"/> Other _____

Please explain the above: _____

5. As a young child, (5-12 years), did any of the following occur?

<input type="checkbox"/> Fall from a tree	<input type="checkbox"/> Bed wetting
<input type="checkbox"/> Fall of a bicycle	<input type="checkbox"/> Hyperactivity/Autism
<input type="checkbox"/> Fall of playground equipment	<input type="checkbox"/> Learning difficulties
<input type="checkbox"/> Sports accident	<input type="checkbox"/> Asthma
<input type="checkbox"/> Car accident	<input type="checkbox"/> Allergies
<input type="checkbox"/> Stomach pains	<input type="checkbox"/> Leg/knee pains
<input type="checkbox"/> Scoliosis	<input type="checkbox"/> Other _____

Please explain the above: _____

6. Tell us about any vaccinations your child has had: _____

Any reactions to any of these? _____

Were you told that you had a choice in vaccinating your child? **___YES ___NO**
Would you like information on the other side of this issue? **___YES ___NO**

7. As a child or adolescent, has your child experienced any of the following:

- | | | |
|--|---|--|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Numbness in arms/hands | <input type="checkbox"/> Foot/ankle/knee pains |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Arm/wrist pains | <input type="checkbox"/> Tingling in arms/legs |
| <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Sleeping problems | <input type="checkbox"/> Neck/back pains |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Allergies | <input type="checkbox"/> Shoulder pains |
| <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> Stomach problems | <input type="checkbox"/> Growing Pains@ |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Weight gain/loss | <input type="checkbox"/> Other _____ |

Please explain any of the above: _____

8. Which of the problems you have checked off is the worst? _____

Is this problem: Constant __, Intermittent __, Occasional __, Cyclic __

9. How long has it persisted? _____

10. When it is at its worst, how does it make your child feel? _____

11. What have you done about it that has NOT worked? _____

12. What makes it worse? _____

13. What effect does this problem have of your child's body functions/daily activities?

14. Describe any hospital stays: _____

15. Approximately how many times have antibiotics been prescribed and for what conditions? _____

16. List any medications your child is currently taking: _____

17. To summarize, what is your purpose for this appointment? _____

18. Is there anything else you feel we should know? _____

Signature of parent or guardian: _____ Date: _____