Child & Adolescent Initial Questionnaire

Appt. Date: _______________ Referred By: ____
Name (first, middle, last) _____________________________________ Preferred Name: ___________________
Address____ City _______________ State ____ Zip_________
Home Phone (____) _____________ Mom Cell (_____) _______________ Dad Cell (_____) ______________
Social Security # ____________________ Date of Birth___/___/___ Age____ □Male □Female
Mother's Name __________________________________Father's Name _______________________________
Email Address: ____

1. Tell us about your pregnancy;

Did you carry to full term? □ Yes □ No If not, how long? _______________________________________
Describe any complications and when they occurred: ____
____

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

Did you use a midwife? □ Yes □ No
Did you go to a hospital? □ Yes □ No
Did you use an obstetrician? □ Yes □ No
Did you have a C-Section? □ Yes □ No
Was it a difficult birth? □ Yes □ No
Were forceps used? □ Yes □ No
Vacuum Extraction? □ Yes □ No
Were you induced? □ Yes □ No
Did you have an Epidural? □ Yes □ No

What was the baby's **APGAR** Score? _________ At 5 minutes? _____________

3. Tell us more:

Did you breastfeed? □ Yes □ No How long? ____________ What formula after? _________________________
Did you consume alcohol during your pregnancy? □ Yes □ No If so, how much? _________________________
Did you smoke? □ Yes □ No If so, how much? _____________ How long? _______________________________
Did you take any medication during your pregnancy? □ Yes □ No
What type and for what? ____
____
Any exposures to ultrasound? □ Yes □ No How many?_________________

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

___ Fall from a change table
___ Tumble down stairs
___ Fall out of crib
___ Involved in car accident
___ Fall off playground equipment
___ Did not gain weight
___ Frequent crying spells
___ Frequent fevers
___ Frequent bouts of diarrhea
___ Constipation
___ Sleeping problems
___ Reaction to vaccination
___ Play in a Jolly Jumper
___ Frequent colds
___ Frequent ear infections
___ Colic
___ Tonsillitis
___ Other: _______________

Please explain the above: ____

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

___ Fall from a tree
___ Sports accident
___ Hyperactivity/Autism
___ Asthma
___ Scoliosis
___ Fall of a bicycle
___ Car accident
___ Learning difficulties
___ Allergies
___ Other: _______________
___ Fall of playground equipment
___ Bed wetting
___ Stomach pains
___ Leg/knee pains

Please explain the above: ____

6. List any vaccinations your child has had:____
____
____
____

Any reactions to these? □ Yes □ No If so, which one? Please describe reaction: _____________________
____
____

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

___ Headaches	___ Numbness in arms/hands	___ Foot/ankle/knee pains
___ Dizziness	___ Arm/wrist pain	___ Tingling in arms/legs
___ Ringing in ears	___ Sleeping problems	___ Neck/back pains
___ Asthma	___ Allergies	___ Shoulder pains
___ Hyperactivity	___ Stomach problems	___ Growing Pains
___ Fatigue	___ Weight gain/loss	___ Other ________

Please explain any of the above: ____
____

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

Is this problem: (circle one): Constant, Intermittent, Occasional, Cyclic
How long has it persisted? ____
When it is at its worst, how does it make your child feel? _____________________________
What have you done about it that has NOT worked? __________________________________
What makes it worse? ____

9. What effect does this problem have on your child's body functions? ___________________________
____

Does it have any effect on his/her participation in daily activities? □ Yes □ No If yes, please explain:
____

10. Describe any hospital stays: ____

11. Approximately how many times have antibiotics been prescribed and for what conditions?
____

12. List any medications your child is currently taking: ___________________________________
____

13. To summarize, what is your purpose for this appointment? ______________________________
____

14. Is there anything else you feel we should know? ____
____
____

Name of parent or guardian: ___________________________________ Date: _________________
Signature of parent or guardian: ____

BestLife
CHIROPRACTIC AND WELLNESS CENTER

Name: ____ Date: _______________

FAMILY HEALTH HISTORY

Please review the diseases and conditions listed below and indicate those that are current health problems of a family member by the designation "C" under his/her column, and those that are past health problems by the designation of "P" under his/her column. Leave blank those spaces which do not apply.

	Father	**Mother**	**Spouse**	**Siblings**				**Children**			
Condition:	**Age: ______**	**Age: ______**	**Age: ______**	**Age: ____**	**Age: ____**	**Age: ____**	**Age: ____**	**Age: ____**	**Age: ____**	**Age: ____**	**Age: ____**
ADHD											
Allergies											
Arthritis											
Asthma											
Autism											
Back Trouble											
Bed Wetting											
Bursitis											
Cancer											
Chest Pain											
Colic											
Constipation											
Crohns Disease											
Depression											
Diabetes											
Diarrhea											
Disc Problems											
Down Syndrome											
Ear Infection											
Emotion Issues											
Emphysema											
Epilepsy											
Headaches											
Migraines											
Heartburn											
Heart Trouble											
High Blood Press											
IBS											
Indigestion											
Infertility											
Insomnia											
Kidney Trouble											
Neck Pain											
Neuritis											
Nervousness											
Pinched Nerve											
Scoliosis											
Sinus Trouble											
Other: __________											

5072 W. Plano Pkwy Plano, TX 75093 972-200-5009

RELEASE AND CONSENTS

AUTHORIZATION FOR DIAGNOSIS AND TREATMENT
I authorize Drs. Steven and Laura Le, DC and whomever they may designate as their assistants to administer diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.

Signature of Responsible Person: ____

Relationship of responsible person: ____________________

CONSENT TO X-RAY EXAMINATIONS
If and when deemed necessary, I do hereby consent to x-ray examination.

Females: I will notify the doctors if I believe that I could be pregnant so that the proper precautions will be taken.
Last Menstrual Period Date __________________________

Signature of Responsible Person: ___________________________________ Date: _______________

AUTHORIZATION TO TREAT A MINOR CHILD

I hereby authorize Drs. Steven and Laura Le, licensed Doctors of Chiropractic in the state of Texas, to administer treatment as deemed necessary to my Son/Daughter/Other: ___________

Child's Name: ____

Signature of Guardian: ____ Date: ______________

Worker's Compensation and Personal Injury:

INSURANCE ASSIGNMENT OF BENEFITS
I hereby instruct and direct my personal injury protection carrier and/or my auto insurance carrier and any liability carriers of any and all person(s) at fault of my injuries, and my attorney to DIRECTLY pay in full to Best Life Chiropractic and Wellness Center, LLC under current insurance policy as payment towards the total charges for the services rendered to me. This is a direct assignment of my rights and benefits under my policy. I further direct my personal injury protection carrier and all other insurance companies involved, to pay Stone Best Life Chiropractic and Wellness Center, LLC directly, overriding any and all powers of attorney which may have been or may be submitted by my attorney. A photocopy of this assignment shall be considered as claims paid, to my insurance companies and/or my attorney.

I have read, understand, and agree to this information:

Signature of Responsible Person: ____Date:_____________

Witness:____

HIPAA Consents

Name of Practice: **Best Life Chiropractic and Wellness Center**

Address: 5072 W. Plano Parkway, Ste. 130, Plano, Texas 75093 and 2800 Corporate Drive, Ste. 100, Flower Mound, Texas 75028

Privacy Contact: Debby Wanga

Telephone: 972-200-5009

NOTICE OF PRIVACY PRACTICE RECEIPT:

I acknowledge that I was provided with the Notice of Privacy Practices of the Chiropractic Practice named at the top of this page.

Printed Name of Patient: X________________________________

Signature of Patient: X________________________________

Date: X______________________

Patient's Date of Birth: X______________________

For Personal Representative of the Patient (only if applicable)

Print Name of Personal Representative: X____________________

Relationship (parent, guardian, etc.): X____________________

Signature of Personal Representative: X____________________

Reason Patient unable to sign: ______________________________

___________________________ ________________________

Practice Employee Date

ALL PATIENTS PLEASE PROVIDE THE FOLLOWING

May we release appointment, billing and medical information to anyone other than you? ___YES ___NO

Name(s) of the person(s) we may release your information to: ___________________________________

* I hereby authorize Best Life Chiropractic and Wellness Centers to release periodic status reports from the medical records of the patient listed below. The reports may be released to other physicians or facilities participating in my care.
* I understand my records are confidential and cannot be disclosed without my written authorization, except otherwise provided by law.
* I understand that records pertaining to the diagnosis and/or treatment of HIV/AIDS testing, psychiatric illness and alcohol or chemical abuse dependency will not be released unless I have given my specific consent to release this information.
* I understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance upon it and that this authorization will automatically expire on one year from date signed.
* I understand that a photocopy or facsimile of this authorization is as valid as the original.
* I authorize the release of any medical billing or other information necessary to process claims on my behalf.
* I agree to be fully responsible for all lawful debts incurred by myself (or dependents under care) for services received from Best Life Chiropractic and Wellness Center, Plano and Flower Mound, Texas.

________________________________ ______________________________________

Signature of Patient Date

____

Print Name

Please initial one box below:

If our office attempts to contact you and a message is taken by an answering machine/voicemail or another person, it is appropriate to leave a:

____ Detailed message regarding condition, appointments, or payments.

____ Message to call Best Life Chiropractic and Wellness Center

NOTICE OF PRIVACY PRACTICES

Effective April 14, 2003

Best Life Chiropractic and Wellness Center is committed to protecting your personal health information. Personal health information may include such items as: medical notes from your doctor, a claim from your provider listing your diagnosis, a medical treatment that you received, or laboratory/diagnostic test results. This notice about protecting your health information is required by law. It tells you about your rights and how we use and disclose your health information.

YOUR HEALTH INFORMATION RIGHTS

- Request a restriction on certain uses and disclosures of your health information; however, we are not required to approve your request.
- Request that we notify you about your health information in a way or at a location that will help you keep your information confidential.
- Receive a list of disclosures we have made of your health information.
- In writing at any time, withdraw your permission for us to disclose your health information, except for the information that we disclose before you stopped your permission.
- Review and obtain a copy of your own health information.
- Ask us to change your health information if you believe it is incorrect or incomplete. We may deny your request and, if so, will give you the reason(s) why the request was denied.
- Receive a paper or electronic copy of this Notice of Privacy Practices upon request.

HOW BEST LIFE CHIROPRACTIC AND WELLNESS CENTER MAY USE OR DISCLOSE YOUR HEALTH INFORMATION

FOR TREATMENT: We may use and disclose your health information to a physician or other healthcare provider providing treatment to you.

PAYMENT: We may use and disclose your health information to obtain payment for services we provided to you.

HEALTHCARE OPERATIONS: We may use and disclose your health information in connection with chiropractic operations, including quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner performance, conducting training programs, accreditation, certification, licensing, or credentialing activities.

REQUIREMENTS BY LAW: We may use and disclose your health information when required to do so by law.

- To reply to proper requests for your health information from a court or other legal agency.
- To report information for public health, such as reporting victims of abuse, neglect or domestic violence or reporting to the Food and Drug Administration problems with products or reactions to medications.
- To report information for public safety, such as to prevent the spread of a serious threat to the health and safety of a particular person or the general public.
- To assist law enforcement officials, such as the police, in their law enforcement duties.
- To allow funeral directors, medical examiners, or coroners to carry out their lawful duties, such as to complete a death certificate for the state.
- To comply with laws and regulations related to Worker’s Compensation.
- To allow other government agencies to provide you with benefits and services.

HEALTH OVERSIGHT ACTIVITIES: We may disclose your health information to government health agencies for health oversight reasons, such as program audits or licensure reviews.
RESEARCH: We may use your health information for approved research purposes, such as for study to cure a disease.
SPECIAL GOVERNMENT FUNCTIONS: We may such as protection of public officials or reporting to various branches of the armed services, may require the use or disclosure of your health information.

OBLIGATIONS OF BEST LIFE CHIROPRACTIC AND WELLNESS

- Maintain the privacy of your protected health information.
- Provide you with the Notice of its legal duties and privacy practices with respect to your health information.
- Obtain your written authorization to use or disclose your health information for reasons other than those listed in this Notice and permitted by law.
- Abide by the terms of this Notice that are currently in effect.
- Notify you if we are unable to agree to requested restriction on how your information is used or disclosed.
- Allow reasonable requests you may make to notify you about your health information in a way or at a location that will help you keep your health information confidential.

Best Life Chiropractic and Wellness reserves the right to change its information practices. The new provisions will be effective for all protected health information that Best Life Chiropractic and Wellness Center maintains. Revised notices will be made available to you by written notices and on the Best Life Chiropractic and Wellness website at: www.bestlifechiro.com

COMPLAINTS:
If you have a complaint about how Best Life Chiropractic and Wellness handles your health information, or if you otherwise believe that your privacy rights have been violated by Best Life Chiropractic and Wellness, your complaint should be directed to:
Best Life Chiropractic and Wellness Center, 5072 W. Plano Parkway, Suite 130, Plano, Texas 75093 (972) 200-5009
Attention: Privacy Contact

If you are not satisfied with the manner in which Best Life Chiropractic and Wellness handles a complaint, you may submit a formal complaint to the U.S. Secretary of Health and Human Services in Washington, D.C. There will be no retaliation by Best Life Chiropractic and Wellness if you file a complaint.