Confidential Parent/Child Health Questionnaire

Name of Child:_____ Name of Parent:_____

Address: _____ Parent's Address (if different from child):_____

City: _____ _____

State: _____ Zip/Postal Code: _____ State:_____ Zip: _____

Home Phone Number: _____ Email Address: _____

Work Phone Number: _____ Child's Date of Birth:_____Age: ____ Sex: M F

Name of Emergency Contact: _____ # of weeks of Pregnancy with child: _____

Phone Number of Emergency Contact: _____ Referred To This Office By: _____

Name of Primary Care Physician (Pediatrician):_____

PCP Address: _____

Who is Responsible For Your Child's Bill: □ You □ Spouse □ Auto Insurance □ Medicare

□ Personal Health Insurance Co.: _____ Health Card Number: _____

Insured Person's Name:_____ Insured Person's Date of Birth: _____

List any concerns you have about your child's health:_____

YES	NO	REGARDING PREGNANCY:
□	□	Did your diet include sugar, white flour, or trans fats?
□	□	Did you experience any back pain during pregnancy?
□	□	Did you consume any alcoholic beverages during pregnancy?
□	□	Did you smoke cigarettes, drink caffeine, or take medications?
□	□	Did you receive any vaccinations or shots?
□	□	Were you physically ill at any time?

List medications taken during pregnancy:_____

_____

YES	NO	REGARDING LABOR/DELIVERY:
□	□	Did you experience back pain during labor?
□	□	Did you experience a difficult or prolonged labor?
□	□	Was your delivery extremely rapid?
□	□	Was your baby's presentation head down?
□	□	Was your baby posterior or breech?
□	□	Was another individual supporting you during labor and delivery?

Did the delivery involve any of the following:

□	□	Forceps
□	□	Vacuum suction
□	□	C-section
□	□	Pulling or twisting of your baby
□	□	Pitocin (chemically induced labor)
□	□	Epidural

YES	NO	NUTRITION:
□	□	Did you breast feed your child? If yes, for how long?_____
□	□	Did your child have difficulty latching on?
		Was your baby formula-fed?
□	□	If yes, what type/brand of formula? _____
□	□	Were solid foods introduced before 6 months?

Did your baby's diet include any of the following **before 1 year old**:

□	□	Cow's milk
□	□	Soy
□	□	Sugar
□	□	Trans-Fats
□	□	Wheat/Grains
□	□	White Flour
□	□	Nuts
□	□	Corn

Does your child's diet include any of the following **currently?**

□	□	Cow's milk
□	□	Sugar
□	□	Artificial Sweeteners (Splenda, Nutrasweet)
□	□	Soda
□	□	White Flour
□	□	Grains or Wheat
□	□	Trans Fats (margarine, packaged foods, etc.)
□	□	Soy
□	□	Does you child have any allergies?

Where was your child delivered: □ Home □ Birthing Center □ Hospital

List any allergies (food or environmental):_____

_____

List your baby's first foods: _____

List your child's favorite food:_____

EMOTIONAL HEALTH:

YES NO

- ☐ ☐ Does your child fail to follow directions?
- ☐ ☐ Is your child hyperactive?
- ☐ ☐ Does your child have difficulty socializing with others?
- ☐ ☐ Does your child have frequent "temper tantrums?"
- ☐ ☐ Does your child get frustrated easily?
- ☐ ☐ Other behavioral problems:_____

MEDICAL HISTORY:

YES NO

- ☐ ☐ Has your child ever taken an antibiotic?
  Total Number of antibiotic prescriptions:_____
  Reason for antibiotics:_____
  _____
- ☐ ☐ Did your child receive any vaccinations?
- ☐ ☐ If yes, did your child experience any behavioral or physical changes after vaccination?
  Describe reactions:_____
  _____
- ☐ ☐ Has your child ever been hospitalized?
  Reason and date of hospitalization:_____
  _____
- ☐ ☐ Has your child had any surgeries?
  List surgeries:_____
- ☐ ☐ Exposure to ultrasound? How many and what was the medical reason?_____

FAMILY HISTORY:

YES NO

- ☐ ☐ Do any other family members have health problems?
  List siblings:
  Brother(s): Age(s) _____
  Sister(s): Age(s) _____

GROWTH AND DEVELOPMENT:

At what age did your child sit up? _____ months
At what age did your child crawl? _____months
At what age did your child walk? _____months
At what age did your child talk? _____months

Child's Height and Weight **at Birth**:
Height: _____ Weight: _____
APGAR scores at birth: _____

Child's Height and Weight **at Last Physical**:
Height: _____ Weight: _____

List any concerns about your child's growth and development:
_____
_____

List your child's current medications and/or Supplementation/vitamins:_____
_____
_____
_____
_____

PHYSICAL TRAUMA :

YES NO

- ☐ ☐ Did your child ever fall when learning to sit-up, stand, walk, run, ride a bike, play sports?
- ☐ ☐ Has your child ever fallen down, tripped, or hit his/her head?
- ☐ ☐ Has your child ever fallen from a height greater than 2ft?
- ☐ ☐ Has your child ever broken a bone, dislocated or sprained a joint?
- ☐ ☐ Has your child ever been in a motor vehicle accident? Date of accident: _____
- ☐ ☐ Does your child carry a backpack greater than 15% of his/her body weight?
- ☐ ☐ Does your child spend more than 1 hour per day in front of the TV, video games, or computer?
- ☐ ☐ Did his/her mother ever fall when pregnant with this child?

List sports played and age began:
_____
_____

HAS YOUR CHILD SUFFERED FROM ANY OF THE FOLLOWING HEALTH PROBLEMS?

YES NO

- ☐ ☐ Torticollis/Wry neck
- ☐ ☐ Reflux/vomiting
- ☐ ☐ Failure to thrive/difficulty gaining weight
- ☐ ☐ Difficulty turning head to one side
- ☐ ☐ Hyperactivity/ADD
- ☐ ☐ Ear Infections
- ☐ ☐ Difficulty Sleeping
- ☐ ☐ Bed Wetting
- ☐ ☐ Irritability
- ☐ ☐ Colic
- ☐ ☐ Frequent Colds
- ☐ ☐ Diarrhea
- ☐ ☐ Constipation
- ☐ ☐ Gas Pains
- ☐ ☐ Rashes/Eczema
- ☐ ☐ Milk/Lactose Intolerance
- ☐ ☐ Food sensitivities
- ☐ ☐ Allergies
- ☐ ☐ Asthma
- ☐ ☐ Headaches
- ☐ ☐ Learning Disorder
- ☐ ☐ Poor Posture
- ☐ ☐ Chicken Pox
- ☐ ☐ Pneumonia
- ☐ ☐ Whooping Cough (Pertussis)
- ☐ ☐ Measles
- ☐ ☐ Flu
- ☐ ☐ Diabetes
- ☐ ☐ Cancer, Leukemia
- ☐ ☐ Back pain
- ☐ ☐ Neck pain
- ☐ ☐ Autism/Autistic spectrum disorder
- ☐ ☐ Weight trouble/overweight
- ☐ ☐ Other _____

healthcarecomplete
Dr. Jennah Dieter, D.C., C.A.C.C.P.
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260 Merrimac St.
Newburyport, MA 01950
978-499-WELL (9355)

CONSENT TO TREATMENT OF MINOR
(CHILD UNDER 18)

I hereby request and authorize the doctor(s) of Integrated Family Wellness PC to perform diagnostic tests and render chiropractic adjustments and other treatments as necessary to my child, the said patient.

This authorization also extends to all other doctors and trained office staff and is intended to include radiographic examination at the doctor's discretion.

As of this date, I have the legal right to select and authorize health care services for the minor child named above.

(If applicable) Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/former spouse or other parent is not required. If my authority to so select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

Signature: _____ Date:_____

Printed Name:_____ Relationship to Patient:_____

Witness: _____

CREDIT CARD PREAUTHORIZATION

Healthcare Complete
260 Merrimac Street-The Towle Building
Newburyport, MA 01950
978-499-WELL (9355)

To better serve our patients, and to give the best care to everyone, we are requiring a credit/debit card to be kept confidentially in each individual's file. Please complete the information below:

Patient Name: _____

I authorize Healthcare Complete to charge my credit card account for patient care under the following circumstances (check off each one that you authorize):

- ☐ Please charge my credit card weekly in pre-payment of my appointments
- ☐ Please charge my credit card after each visit
- ☐ My bill is over 90 days past due, and an attempt to reach me by phone or mail has been made, without response.
- ☐ My insurance didn't cover a service I received, and an attempt to reach me by phone or mail has been made, without response.

Circle one: MasterCard Visa Other _____

Charge Account Number: _____ Exp. Date _____

Cardholder Name: _____

I understand that this form is valid for one year unless I cancel the authorization with written notice to Healthcare Complete.

Cardholder Signature _____ Date _____