

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: _____

<p>YES NO REGARDING PREGNANCY:</p> <p><input type="checkbox"/> <input type="checkbox"/> Did your diet include sugar, white flour, or trans fats?</p> <p><input type="checkbox"/> <input type="checkbox"/> Did you experience any back pain during pregnancy?</p> <p><input type="checkbox"/> <input type="checkbox"/> Did you consume any alcoholic beverages during pregnancy?</p> <p><input type="checkbox"/> <input type="checkbox"/> Did you smoke cigarettes, drink caffeine, or take medications?</p> <p><input type="checkbox"/> <input type="checkbox"/> Did you receive any vaccinations or shots?</p> <p><input type="checkbox"/> <input type="checkbox"/> Were you physically ill at any time?</p> <p>List medications taken during pregnancy: _____</p> <hr/> <p>YES NO REGARDING LABOR/DELIVERY:</p> <p><input type="checkbox"/> <input type="checkbox"/> Did you experience back pain during labor?</p> <p><input type="checkbox"/> <input type="checkbox"/> Did you experience a difficult or prolonged labor?</p> <p><input type="checkbox"/> <input type="checkbox"/> Was your delivery extremely rapid?</p> <p><input type="checkbox"/> <input type="checkbox"/> Was your baby's presentation head down?</p> <p><input type="checkbox"/> <input type="checkbox"/> Was your baby posterior or breech?</p> <p><input type="checkbox"/> <input type="checkbox"/> Was another individual supporting you during labor and delivery?</p> <p>Did the delivery involve any of the following:</p> <p><input type="checkbox"/> <input type="checkbox"/> Forceps</p> <p><input type="checkbox"/> <input type="checkbox"/> Vacuum suction</p> <p><input type="checkbox"/> <input type="checkbox"/> C-section</p> <p><input type="checkbox"/> <input type="checkbox"/> Pulling or twisting of your baby</p> <p><input type="checkbox"/> <input type="checkbox"/> Pitocin (chemically induced labor)</p> <p><input type="checkbox"/> <input type="checkbox"/> Epidural</p>	<p>YES NO NUTRITION:</p> <p><input type="checkbox"/> <input type="checkbox"/> Did you breast feed your child? If yes, for how long? _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Did your child have difficulty latching on? Was your baby formula-fed?</p> <p><input type="checkbox"/> <input type="checkbox"/> If yes, what type/brand of formula? _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Were solid foods introduced before 6 months?</p> <p>Did your baby's diet include any of the following before 1 year old:</p> <p><input type="checkbox"/> <input type="checkbox"/> Cow's milk</p> <p><input type="checkbox"/> <input type="checkbox"/> Soy</p> <p><input type="checkbox"/> <input type="checkbox"/> Sugar</p> <p><input type="checkbox"/> <input type="checkbox"/> Trans-Fats</p> <p><input type="checkbox"/> <input type="checkbox"/> Wheat/Grains</p> <p><input type="checkbox"/> <input type="checkbox"/> White Flour</p> <p><input type="checkbox"/> <input type="checkbox"/> Nuts</p> <p><input type="checkbox"/> <input type="checkbox"/> Corn</p> <p>Does your child's diet include any of the following currently?</p> <p><input type="checkbox"/> <input type="checkbox"/> Cow's milk</p> <p><input type="checkbox"/> <input type="checkbox"/> Sugar</p> <p><input type="checkbox"/> <input type="checkbox"/> Artificial Sweeteners (Splenda, Nutrasweet)</p> <p><input type="checkbox"/> <input type="checkbox"/> Soda</p> <p><input type="checkbox"/> <input type="checkbox"/> White Flour</p> <p><input type="checkbox"/> <input type="checkbox"/> Grains or Wheat</p> <p><input type="checkbox"/> <input type="checkbox"/> Trans Fats (margarine, packaged foods, etc.)</p> <p><input type="checkbox"/> <input type="checkbox"/> Soy</p> <p><input type="checkbox"/> <input type="checkbox"/> Does your child have any allergies?</p>
<p>Where was your child delivered: <input type="checkbox"/> Home <input type="checkbox"/> Birthing Center <input type="checkbox"/> Hospital</p> <p>List any allergies (food or environmental): _____</p> <p>_____</p> <p>List your baby's first foods: _____</p> <p>List your child's favorite food: _____</p>	

YES NO EMOTIONAL HEALTH:

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: _____

YES NO MEDICAL HISTORY:

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? _____

YES NO FAMILY HISTORY:

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: _____

YES NO PHYSICAL TRAUMA :

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

- Individualized Family Chiropractic Care
- Customized Nutritional Counseling
- Pediatric & Perinatal Certified
- Rehabilitative Exercise

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.

- Check here if you wish to give consent for the minor to receive medical care without an accompanying adult. This consent may only apply to minors age 16 and older. This consent shall be in effect for:**
- Date _____ (only)**
 - Indefinitely, until revoked by written communication**

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.

Patient Signature _____ Date _____
