PEDIATRIC QUESTIONNAIRE

Name: (Last, First MI)_____ **Today's Date:** _____

PEDIATRIC REVIEW OF SYSTEMS

Pediatric:

- ☐ ADHD
- ☐ Allergies/Asthma
- ☐ Autism
- ☐ Back/Neck Pain
- ☐ Bed Wetting
- ☐ Behavioral issues
- ☐ Chronic Earaches
- ☐ Colic
- ☐ Constipation
- ☐ Growing Pains
- ☐ Nightmares
- ☐ Reflux
- ☐ *None in this Category*

Childhood Diseases:

- ☐ Chicken Pox: Age ____
- ☐ Measles: Age ____
- ☐ Meningitis: Age ____
- ☐ Mumps: Age ____
- ☐ Rubella: Age ____
- ☐ Tuberculosis: Age ____
- ☐ Whooping Cough: Age ____
- ☐ Other:_____ Age ____
- ☐ *None in this Category*

Has your child been vaccinated?

☐ **No** ☐ **Yes**

*(Any Adverse Reactions? – Describe:)*_____

_____

INFANTS AND NEWBORNS

Prenatal History:

Location of Birth: ☐ Home ☐ Birthing Center ☐ Hospital

Birth Weight: _____ **Birth Length:** _____ **Full Term?** ☐ **No** ☐ **Yes** *(Describe)*_____

Complications during pregnancy? ☐ **No** ☐ **Yes** *(Describe)* _____

Medications during pregnancy or delivery? ☐ **No** ☐ **Yes** *(List)* _____

Cigarette / Alcohol / Drugs during pregnancy? ☐ **No** ☐ **Yes** *(List)* _____

Birth Interventions? ☐ **No** ☐ **Yes** ☐ Forceps ☐ Vacuum ☐ Caesarian ☐ Other: _____

Complications during delivery? ☐ **No** ☐ **Yes** *(Describe)* _____

Feeding History:

Breast fed? ☐ **No** ☐ **Yes** *(How Long?)* _____ **Formula fed?** ☐ **No** ☐ **Yes** *(How Long?)* _____ *(Type?)* _____

Introduced to cereal at ____ months old. **Solids at____ months old.** **Cow's milk at____ months old.**

Food / Juice allergies or intolerances? ☐ **No** ☐ **Yes** *(Describe)* _____

Developmental History:

Sleep *(Hours per Night?)* _____ **Problems Sleeping?** *(Describe)* _____ _____

CONSENT FOR TREATMENT OF A MINOR

I hereby authorize: _____ *(Doctor's Name)* and whomever he or she may designate as assistants to administer examinations and chiropractic care as deemed necessary to: _____ *(Minor Patient's Name)*

_____
Printed Name of Parent or Guardian

_____ _____
Signature of Parent or Guardian Date

_____ _____
Witness Date

Patient No: _____

INTRODUCTION PATIENT CASE HISTORY

Today's Date: ____/____/_____

PATIENT INFORMATION

Name: *(First MI Last)* _____ **Preferred Name**: _____

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

Date of Birth: _____ **Gender:** ☐ Male ☐ Female **Social Security #**:_____

Home: _____ **Mobile:** _____ **Work:** _____

Email: _____

Preferred Method of Contact: ☐ Text ☐ Email ☐ Phone - *Home, Mobile, or Work* ☐ Other: _____

***Referred By:** *(Name)* _____

☐ Family ☐ Friend ☐ Co-Worker ☐ Doctor ☐ Other: _____

Race & Ethnicity: *(Choose up to 2)*

- ☐ African American or Black
- ☐ American Indian or Alaskan Native
- ☐ Asian
- ☐ Hispanic or Latino
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White
- ☐ Decline

Preferred Language:

- ☐ English
- ☐ Spanish
- ☐ Other: _____
- ☐ Decline

EMERGENCY CONTACT INFORMATION

Name: *(First MI Last)* _____ **Primary Care Physician:** _____

Home: _____ **Mobile:** _____ **Doctor's Phone:** _____

Relationship:

☐ Child ☐ Parent ☐ Spouse ☐ Other: _____

FINANCIAL INFORMATION

Is today's visit the result of an accident?

☐ No ☐ Auto ☐ Work ☐ Other: _____

Will we be working with insurance? ☐ No ☐ Yes *(Details)*

Primary: _____ *ID#:* _____

Secondary: _____ *ID#:* _____

Where would you like statements sent?

☐ Self ☐ Other *(Details below)*

Name: _____

Address: _____

Phone: _____ *Email:* _____

It is Usual and Customary to Pay for Services as Rendered Unless Otherwise Arranged

Account No: _____

INNATE INTELLIGENCE WITHIN

Revision Date 07/17/2019

HISTORY OF PRESENT ILLNESS

HISTORY OF PRESENT ILLNESS *(Please describe)*

Major Complaint: _____ **Secondary Complaints:** _____

_____ _____

_____ _____

When did it start? ____/____/_____ **What happened?** _____

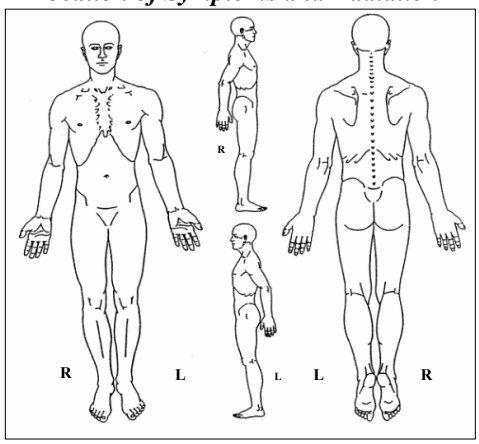
_____

Which daily activities are being affected by this condition? _____

_____

MAJOR COMPLAINT

Location of Symptoms and Radiation



P __ Pain
N __ Numb
S __ Spasm

T__ Tender
H__ Hypoesthesia

Grade Intensity/Severity:

- ☐ None (0/10)
- ☐ Mild (1-2/10)
- ☐ Mild-Moderate (2-4/10)
- ☐ Moderate (4-6/10)
- ☐ Moderate-Severe (6-8/10)
- ☐ Severe (8-10/10)

Frequency:

- ☐ Off & On
- ☐ Constant

Quality:

- ☐ Sharp
- ☐ Stabbing
- ☐ Burning
- ☐ Achy
- ☐ Dull
- ☐ Stiff & Sore
- ☐ Other: _____

Does it radiate?

☐ No ☐ Yes *(Please indicate on drawing)*

Improves with:

- ☐ Ice
- ☐ Heat
- ☐ Movement
- ☐ Stretching
- ☐ OTC Medications: _____
- ☐ Other: _____

Worsens with:

- ☐ Sitting
- ☐ Standing/Walking
- ☐ Lying Down/Sleeping
- ☐ Overuse/Lifting
- ☐ Other: _____

Previous Treatment:

- ☐ None
- ☐ Chiropractor _____
- ☐ Medical Doctor _____
- ☐ Physical Therapy _____
- ☐ ER/Urgent Care _____
- ☐ Orthopedic _____
- ☐ Other: _____

Previous Diagnostic Testing:

- ☐ None
- ☐ X-rays _____
- ☐ MRI _____
- ☐ CT _____
- ☐ Other: _____

Women:** ***Are you pregnant?

☐ No *Last Menstrual Period:* ___/___/____

☐ Yes *Due date:* ___/___/____

Present Illness Comments:

_____

_____

_____

_____

_____

_____

Prescription Medications & Supplements: ☐ None

☐ Yes *(List – Name, dosage, frequency)* _____

_____

_____

_____

_____

_____

Allergies to Medications: ☐ No known drug allergies

☐ Yes *(List - Name and reaction)* _____

_____

_____

_____

_____

_____

PAST, FAMILY, AND SOCIAL HISTORY

PAST MEDICAL HISTORY

Have you *ever* had any of the following? *(Please select all that apply and use comments to elaborate.)*

Illnesses:

- ☐ Asthma
- ☐ Autoimmune Disorder (*Type*) _____
- ☐ Blood Clots
- ☐ Cancer (*Type*) _____
- ☐ CVA/TIA (stroke)
- ☐ Diabetes
- ☐ Migraine Headaches
- ☐ Osteoporosis
- ☐ Other: _____

Injuries:

- ☐ Back Injury
- ☐ Broken Bones
- ☐ Head Injury
- ☐ Neck Injury
- ☐ Falls
- ☐ Other: _____

Hospitalizations: *(Non-surgical with Date)*

_____

_____

Surgeries: *(If yes, provide type & surgery date)*

- ☐ Cancer _____
- ☐ Orthopedic
  - Shoulder – R / L _____
  - Elbow/Forearm – R / L _____
  - Wrist/Hand – R / L _____
  - Hip – R / L _____
  - Knee – R / L _____
  - Ankle/Foot – R / L _____
- ☐ Spinal Surgery
  - Neck: _____
  - Back: _____
- ☐ Other: _____

_____

_____

Medical History Comments:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

FAMILY HISTORY *(Please mark **X** to all that apply and use comments to elaborate.)*

☐ Unknown ☐ Unremarkable

	Mother	Father	Sibling1	Sibling2	Sibling3	Child1	Child2	Child3
Gender	F	M						
Age at death *(if Deceased)*								
Aneurysms								
CVA (Stroke)								
Cancer								
Diabetes								
Heart Disease								
Hypertension								
Other Family History								

Family History Comments:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

SOCIAL AND OCCUPATIONAL HISTORY

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Other

Children: ☐ None ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ Other:_____

Student Status: ☐ Full Student ☐ Part Student ☐ Non-Student

Highest level of Education: ☐ High School ☐ College Grad.

☐ Post Grad. ☐ Other: _____

Employed: ☐ No ☐ Yes (*Occupation)* _____

Dominant Hand: ☐ Right ☐ Left ☐ Ambidextrous

Smoking/Tobacco Use: *If current smoker, amount =* _____

☐ Every Day ☐ Some Days ☐ Former ☐ Never

Alcohol Use:

☐ Every Day ☐ Weekly ☐ Occasionally ☐ Never

Caffeine Use:

☐ Coffee ☐ Tea ☐ Energy Drinks ☐ Soda ☐ Never

Exercise frequency:

☐ Daily ☐ 3-4xs/week ☐ 2-3xs/week ☐ Rarely ☐ Never

Social History Comments: _____

_____

_____

_____

_____

_____

_____

_____

REVIEW OF SYSTEMS

Many of the following conditions respond to chiropractic treatment.

Are you *currently* experiencing any of these symptoms? *(Please select all that apply and use comments to elaborate.)*

Constitutional: *(General)*
- ☐ Fever
- ☐ Fatigue
- ☐ Other: ______________________
- ☐ *None in this Category*

Musculoskeletal:
- ☐ Joint Pain/Stiffness/Swelling
- ☐ Muscle Pain/Stiffness/Spasms
- ☐ Broken Bones_________________
- ☐ Other: ______________________
- ☐ *None in this Category*

Neurological:
- ☐ Dizziness or Lightheaded
- ☐ Convulsions or Seizures
- ☐ Tremors
- ☐ Other: ______________________
- ☐ *None in this Category*

Psychiatric: *(Mind/Stress)*
- ☐ Nervousness/Anxiety
- ☐ Depression
- ☐ Sleep Problems
- ☐ Memory Loss or Confusion
- ☐ Other: ______________________
- ☐ *None in this Category*

Genitourinary:
- ☐ Frequent or Painful Urination
- ☐ Blood in Urine
- ☐ Incontinence or Bed Wetting
- ☐ Painful or Irregular Periods
- ☐ Other: ______________________
- ☐ *None in this Category*

Gastrointestinal:
- ☐ Loss of Appetite
- ☐ Blood in Stool or Black Stool
- ☐ Nausea or Vomiting
- ☐ Abdominal Pain
- ☐ Frequent Diarrhea
- ☐ Constipation
- ☐ Other: ______________________
- ☐ *None in this Category*

Cardiovascular & Heart:
- ☐ Chest Pains/Tightness
- ☐ Rapid or Heartbeat Changes
- ☐ Swelling of Hands, Ankles, or Feet
- ☐ Other: ______________________
- ☐ *None in this Category*

Respiratory:
- ☐ Difficulty Breathing
- ☐ Cough
- ☐ Other: _________________
- ☐ *None in this Category*

Eyes & Vision:
- ☐ Eye Pain
- ☐ Blurred or Double Vision
- ☐ Sensitivity to Light
- ☐ Other: ______________________
- ☐ *None in this Category*

Head, Ears, Nose, & Mouth/Throat:
- ☐ Frequent or Recurrent Headaches
- ☐ Ear - Ache/Ringing/Drainage
- ☐ Hearing Loss
- ☐ Sensitivity to Loud Noises
- ☐ Sinus Problems
- ☐ Sore Throat
- ☐ Other: ______________________
- ☐ *None in this Category*

Endocrine:
- ☐ Infertility
- ☐ Recent Weight Change
- ☐ Eating Disorder
- ☐ Other: ______________________
- ☐ *None in this Category*

Hematologic & Lymphatic:
- ☐ Excessive Thirst or Urination
- ☐ Cold Extremities
- ☐ Swollen Glands
- ☐ Other: ______________________
- ☐ *None in this Category*

Integumentary: *(Skin, Nails, & Breasts)*
- ☐ Rash or Itching
- ☐ Change in Skin, Hair, or Nails
- ☐ Non-healing Sores or Lesions
- ☐ Change of Appearance of a Mole
- ☐ Breast Pain, Lump, or Discharge
- ☐ Other: ______________________
- ☐ *None in this Category*

Allergic/Immunologic:
- ☐ Food Allergies
- ☐ Environmental Allergies
- ☐ Other: ______________________
- ☐ *None in this Category*

Review of Systems Comments:

____

I have answered these questions to the best of my knowledge and certify them to be true and correct.

Patient or Guardian Signature ____ Date______________________

Michael Malloy, D.C. 6800 Harris Pkwy, Fort Worth, TX 76132 Ph: 817-346-1111 Fax: 855-715-0886
www.Malloychiro.com

Terms of Acceptance

Patient Name: _____ DOB: _____ Date: _____

Before this office begins any health care operations, we require you to read and sign this form stating that you understand the below item. If you refuse to sign this form the doctor reserves the right to refuse care.

AUTHORIZATION: By signing below you authorized this office/provider to complete consultation and examination on the above.

AUTHORIZATION FOR X-RAY WITH RELEASE: By signing below you have declared, to the best of your knowledge, that there is no chance you are pregnant at this time. By signing below, you have declared that you have no known limitations that would be contraindicated for an x-ray evaluation. By signing below, you consent to the taking of x-rays if there is a determined need.

ACKNOWLEDGEMENT OF ASSIGNMENT OF BENEIFITS: By signing below, you have acknowledged that you are fully responsible for all services rendered. By signing below, you furthered acknowledge understanding that your health and accident insurance information polices are an arrangement between you and your carrier, and that you may be required to pay some or all of the fees charged to your account. By signing below, you hereby assign benefits to paid directly to this office/provider by your third-party payer, e.g. insurance company, attorney, etc. By signing below, you agree that this is a non-rescindable agreement and failure to fulfill this obligation will be considered a breach of contract between you and this office.

CMS-1500 HEALTH INSURANCE CLAIM FORM: By signing below, you acknowledge and agree that the CMS-1500 Health Insurance Claim Form Box 12 and Box 13 will state "Signature on File". Box 12 read as follows "PATIENTS OR AUTHORIZED PERSON'S SIGNTURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignments below." Box 13 reads as follows "INSURED OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or suppler for services described below."

CLINICAL SUMMARY REPORT (CSR): I understand that a clinical summary report is created after each visit for the purpose of EHR and is available for my review. At this time, I am asking Malloy Chiropractic to save these documents electronically for me and not print them out after each visit. I understand that upon request these reports are available to be printed or emailed to me for review.

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES: We are very concerned with protecting your personal health information. There may be times our office may need to contact you regarding office matters. By signing below, you have authorized this office to contact you for office related matters in the following manner: phone, work, home, mobile, email and regular mail. Messages may be left on an answering device/voicemail, or with the person answering your phone, home, work, mobile. Also, in accordance with the Health Insurance Portability and Accountability act of 1996 {HIPPA}, updated September 23, 2013, this office obliges to supply you with a copy of the office privacy policies and procedures upon request. This document outlines the use and limitations of the disclosure of your personal health information and your rights as a patient. By signing below, you have acknowledged that you have been offered a copy of this document.

ACKNOWLEDGEMNT OF TREATMENT PLAN: By signing below I acknowledge that, if accepted for care, I may be presented with a chiropractic treatment plan resulting in one or more of the following services: chiropractic adjustments, examinations, and supportive therapies and procedures.

ACKNOWLEDGMENT: By signing below you have acknowledged that you understand and agree with the policies and procedures outlined in this TERMS of ACCEPTANCE form. By signing below, you acknowledge and certify that all the information given to the office/provider in the INTAKE forms are true and accurate to the best of your knowledge.

PRIMARY CARE PHYSICIAN RELEASE: To improve the quality and continuity of your care, do we have your permission to send our notes and reports to your Primary Care Physician (PCP)? ☐ Yes ☐ No

Signature of Patient or Parent (Legal Guardian): _____

Michael Malloy, D.C. 6800 Harris Pkwy, Fort Worth, TX 76132 Ph: 817-346-1111 Fax: 855-715-0886
www.Malloychiro.com

Consent for Chiropractic Services

By reading below I have been made aware:

1. The process of delivering a "Chiropractic Adjustment (manipulation)" may be performed manually, with a table mechanism, or with an instrument to the vertebra(e) of the spine and/or associated structures (legs, arms, etc.), often resulting in an audible pop or click sound.
2. As an addition to the Chiropractic Adjustments "Supportive Therapies and/or Procedures" may be applied by the chiropractor or by staff under the chiropractor's direction or supervision incorporating the use of light, sound, vibration, electricity, traction, motion, bracing, nutritional advice, heat, or cold.
3. That on occasion some temporary soreness and/or stiffness may occur; less frequently aggravation of presenting symptoms or initiation of new symptoms; rarely bruising, swelling, even more rare separation/fracture; and extremely rare, nerve or vascular injury may occur in conjunction with the process of a Chiropractic Adjustment.
4. That the chiropractor has made no guarantee of a positive outcome from treatment.

Additionally:

1. I have been afforded ample opportunity for questions and answers.

Therefore, by signing below:

I **consent** to the performance of the diagnostic and therapeutic procedures performed by the doctor and or staff under the direction and supervision of the office chiropractor(s) involved in my case.

I **consent** to the performance of other diagnostic and therapeutic procedures in the future that may be deemed reasonable and necessary by the doctor and or staff under the direction and supervision of the office chiropractor(s) involved in my case.

Patient Signature: _____

Witness Signature: _____