## Pediatric Patient Questionnaire

CONFIDENTIAL P	ATIENT INFO	RMATION						
Child's Name:			Parent/Gua	ardian Name(s):				
Street Address:		VIII III III III III III III III III II	City, State,	Zip:	White comes and a feel of the company of the compan	- Per manuscus a manuscus de l'el servicione que distributad de la la delenista e manusc		· · · · · · · · · · · · · · · · · · ·
Cell Phone:			Other Phor	ne:		Child's Sex:	O M	O F
Email:			Child's SS #		******	Birthdate:		Age:
How did you hear abou						Weight:		Height:
Who is your primary ca					-			
Is your child receiving ca - If yes, please name th	em and their spe	cialty:						
Please list any drugs/m	edications/vitam	ins/herbs/othe	that your child	is taking:	- Constant		-	41
1								
CURRENT HEALT	H CONDITIO	NS						
What health condition(	s) bring your child	d to be evaluate	ed by a chiroprac	itor?				
When did the condition	ı first begin?			How did the pr	oblem start? O Su	ddenly () Gradua	llv O Po	ost-Iniurv
Has your child ever rece - If yes, please explain:	eived care for this	condition befo	re? O Yes O N	10	f		., .	obe injury
Is this condition: O Ge	tting worse O	Improving C	Intermittent (	Constant Ol	Jnsure			
What makes the proble	m better?			What mal	kes the problem wor	 rse?		
HEALTH GOALS F	OR YOUR C	HILD	THE RELEX	No. IL	2000 (10) 10	Terms IV. III	1 5 5 7 1	
HEALTH GOALS F							om chiror	oractic care?
Section of the last of the las	e health goals fo	or your child:			What would	you like to gain fro		oractic care?
What are your top thre  1. 2.	e health goals fo	or your child:			What would	you like to gain fro		practic care?
What are your top thre  1  2  3.	e health goals fo	or your child:		noir name?	What would	you like to gain fro		oractic care?
What are your top three  1  2  3. Have you ever visited a	e health goals for the chiropractor?	or your child:	If yes, what is th		What would O Resolve O Overall O Both	you like to gain from existing condition wellness		oractic care?
What are your top three  1 2 3. Have you ever visited a What is their specialty?	chiropractor? C	or your child:  Yes O No O Physical Th	If yes, what is th		What would O Resolve O Overall O Both	you like to gain from existing condition wellness		oractic care?
What are your top three  1  2  3. Have you ever visited a	chiropractor? C O Pain Relief  ERTILITY HIS	or your child:  Yes O No O Physical Th	If yes, what is th		What would O Resolve O Overall O Both	you like to gain from existing condition wellness		oractic care?
What are your top three  1 2 3. Have you ever visited a What is their specialty?  PREGNANCY & FE	chiropractor? C O Pain Relief  ERTILITY HIS	or your child:  Yes O No O Physical Th	If yes, what is therapy & Rehab		What would O Resolve O Overall O Both	you like to gain from existing condition wellness		oractic care?
What are your top three  1 2 3. Have you ever visited a What is their specialty?  PREGNANCY & FE Please tell us about you	chiropractor? C O Pain Relief  ERTILITY HIS ur pregnancy	Yes O No O Physical The	If yes, what is therapy & Rehabexxplain:		What would O Resolve O Overall O Both	you like to gain from existing condition wellness		oractic care?
What are your top three  1 2 3. Have you ever visited a What is their specialty?  PREGNANCY & FE Please tell us about you Any fertility issues?	chiropractor? C O Pain Relief  ERTILITY HIS Ur pregnancy O Yes O No	Yes O No O Physical The	If yes, what is the erapy & Rehab explain:		What would O Resolve O Overall O Both	you like to gain from existing condition wellness		oractic care?
What are your top three  1	chiropractor? C O Pain Relief  ERTILITY HIS Ur pregnancy O Yes O No O Yes O No	Yes O No O Physical The	If yes, what is the erapy & Rehab explain: any per week? any per week?		What would O Resolve O Overall O Both	you like to gain from existing condition wellness		oractic care?
What are your top three  1	chiropractor? C O Pain Relief  ERTILITY HIS Ur pregnancy O Yes O No O Yes O No O Yes O No	Yes O No O Physical The OTORY  If yes, please of the second of the secon	If yes, what is the erapy & Rehab explain: any per week? any per week? any per week?		What would O Resolve O Overall O Both	you like to gain from existing condition wellness		oractic care?
What are your top three  1	chiropractor? C O Pain Relief  ERTILITY HIS Ur pregnancy O Yes O No	Yes O No O Physical The TORY  If yes, please each of yes, please e	If yes, what is therapy & Rehab explain: any per week? any per week? axplain: axplain: axplain:	O Nutritional	What would O Resolve O Overall O Both	you like to gain from existing condition wellness		oractic care?
What are your top three  1	chiropractor? C O Pain Relief  ERTILITY HIS Ur pregnancy O Yes O No	Yes O No O Physical The TORY  If yes, please each of yes, please e	If yes, what is therapy & Rehab explain: any per week? any per week? axplain: axplain: axplain:	O Nutritional	What would O Resolve O Overall O Both	you like to gain from existing condition wellness		oractic care?

LABOR & DELIVERY HISTORY				
Child's birth was: O Natural vaginal birth O Scheduled C-section	n O Emergency C-section At how many week's was your child born?			
Child's birth was: O At home O At a birthing center O At a hospit	al O Other: Doctor/Obstetrician's Name:			
Please check any applicable interventions or complications:				
☐ Breech ☐ Induction ☐ Pain meds ☐ Epidural ☐ Episiotom	y 🔾 Vacuum extraction 🔾 Forceps 🔾 Other ————————————————————————————————————			
Please describe any other concerns or notable remarks about your ch	nild's labor and/or delivery.			
Child's birth weight: Child's birth height: APGAR so	core at birth: APGAR score after 5 minutes:			
GROWTH & DEVELOPMENT HISTORY				
Is/was your child breastfed? O Yes O No If yes, how long?	Difficulty with breastfeeding? O Yes O No			
Did they ever use formula? O Yes O No If yes, at what age?	If yes, what type?			
Did/does your child ever suffer from colic, reflux, or constipation as ar - If yes, please explain:	infant? O Yes O No			
Did/does your child frequently arch their neck/back, feel stiff, or bang - If yes, please explain:	their head? O Yes O No			
At what age did the child: Respond to sound: Follow an ob- Sit alone: Crawl: Wall	oject: Hold their head up: Vocalize: Teethe: k: Begin cow's milk: Begin solid foods:			
Please list any food intolerance or allergies, and when they began:				
Please list your child's hospitalization and surgical history, including th	ie year:			
Please list any major injuries, accidents, falls and/or fractures your child	d has sustained in his/her lifetime, including the year:			
	J = 7			
Have you chosen to vaccinate your child? O No Yes, on a de - If yes, please list any vaccination reactions:	layed or selective schedule O Yes, on schedule			
Has your child received any antibiotics? O Yes O No - If yes, how many times and list reason:				
Night terrors or difficulty sleeping? O Yes O No If yes,	, please explain:			
Behavioral, social or emotional issues? O Yes O No If yes,	lo If yes, please explain:			
How many hours per day does your child typically spend watching a T				
How would you describe your child's diet? O Mostly whole, organic f	oods			
ACKNOWLEDGMENT & CONSENT				
Patient Signature:	Date:			

## Patient Review of Systems

THE NERVOUS SYSTEM CONTROLS AND COORDINATES ALL ORGANS AND STRUCTURES OF THE HUMAN BODY

Please check the corresponding boxes for each symptom or condition you have experienced – including both past and present.

	REGIONS	FUNCTIONS	SYMP	PTOMS
The state of the s	Cervical	<ul> <li>Autonomic Nervous System</li> <li>ENT System</li> <li>Vision, Balance &amp; Coordination</li> <li>Speech</li> <li>Immune System</li> <li>Digestive System</li> <li>Nerve Supply to Shoulders, Arms &amp; Hands</li> <li>Sympathetic Nucleus</li> <li>Metabolism</li> </ul>	Colic & Excessive Crying Ear & Sinus Infections Allergies & Congestion Immune Deficiency Headaches & Migraines Vertigo & Dizziness Sore Throat & Strep Swollen Tonsils & Adenoids Vision & Hearing Issues Low Energy & Fatigue Difficulty Sleeping Pain, Numbness & Tingling in Arms to Hands	Epilepsy & Seizures  Sensory & Spectrum  ADD / ADHD  Focus & Memory Issues  Anxiety & Stress  Balance & Coordination  Speech Issues  TMJ / Jaw Pain  Stiff Neck & Shoulders  Depression  High Blood Pressure  Poor Metabolism & Weight Control
	Upper Thoracic	<ul> <li>Upper G.l.</li> <li>Respiratory System</li> <li>Cardiac Function</li> </ul>	Reflux / GERD Chronic Colds & Cough Asthma	Bronchitis & Pneumonia Functional Heart Conditions
	lilos Financia	<ul><li>Major Digestive Center</li><li>Detox &amp; Immunity</li></ul>	Gallbladder Pain / Issues Jaundice Fever	Indigestion & Heartburn Stomach Pains & Ulcers Blood Sugar Problems
	Lower Thoracic	<ul> <li>Stress Response</li> <li>Filtration &amp; Elimination</li> <li>Gut &amp; Digestion</li> <li>Hormonal Control</li> </ul>	Behavior Issues Hyperactivity Chronic Fatigue Chronic Stress	Allergies & Eczema Skin Conditions / Rash Kidney Problems Gas Pain & Bloating
		<ul> <li>Lower G.I. (Absorption &amp; Motility)</li> <li>Gut-Immune System</li> <li>Major Hormonal Control</li> </ul>	Constipation Chrohn's, Colitis & IBS Diarrhea Bed-wetting Bladder & Urination Issues Cramps & Menstrual Issues Cysts & Endometriosis Infertility Impotency Hemorrhoids	Sciatica & Radiating Pain Lumbopelvic / SI Joint Pain Hamstring Tightness Disc Degeneration Leg Weakness & Cramps Poor Circulation & Cold Feet Knee, Ankle & Foot Pain Weak Ankles & Arches Lower Back Pain Gluten & Casein Intolerance
*	Patient Name_		:	Date



## Electronic Health Records Intake Form

This form complies with CMS EHR incentive program requirements

First Name:		Las	st Name:	1	
Email address:					
Preferred method of co	mmunication for p	patient remino	lers (Circle one): Er	nail / Phone / M	ail
DOB://	Gender (Circle one	e): Male / Fer	nale <b>Preferred L</b>	anguage:	
Smoking Status (Circle	one): Every Day Sm	oker / Occasio	nal Smoker / Forme	er Smoker / Nev	er Smoked
Smoking Start Date (Op					
Family Medical History	(Record one diagn	osis in vour fa	mily history and th		
Diagnosis	Father	Mother	Sibling:	Offspring:	
(Write in below)	2		(	Offspring:	,
Example: Heart Disease		X		J \	
					_
Ethnicity (Circle one): H  Are you currently ta  Medicatio	king any medicatio	ns? (Include re		he counter medi	cations)
			g and requestoy (	ne. Sing once a	uay, etc.)
Do you have any medica	tion allergies?				
Medication Name	e Reaction		Onset Date	Additional Comments	
☐ I choose to decline re	ceipt of my clinical	summary afte	er every visit (These	summaries are	often hlank as a
result of the nature an	d frequency of chird	opractic care.)			oj tan siam us u
Patient Signature:				Date:	
For office use only					
Height: We	eight:B	lood Pressure	:/ н	R Tom	P



Dr. Monique Weddle, DC Dr. William R McGowan, DC

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Fax: 910-755-5484

## INFORMED CONSENT FOR CHIROPRACTIC CARE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective. It is important that each patient understands both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits.

Chiropractic is a science and art which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may affect the restoration and preservation of health. Health is a state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.

One disturbance to the nervous system is called a vertebral subluxation. This occurs when one or more of the 24 vertebrae in the spinal column become misaligned and/or do not move properly. This causes alteration of nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by an adjustment. An adjustment is the specific application of forces to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine. Adjustments are usually done by hand, but may be performed by handheld instruments. In addition, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be included.

If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risks, and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis. Print Name Signature Date Consent to evaluate and adjust a minor/child: , being the parent or legal guardian of have read and fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care. Signature Date Pregnancy Release: This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child. Date of last menstrual cycle:

Signature

Date