LOUISVILLE FAMILY CHIROPRACTIC

8117 New LaGrange Rd. Louisville, KY 40222 502-326-9950 www.lfchiro.net

Initial Child & Adolescent Questionnaire

Child's Name: _____

Mom: _____ Dad: _____

Date of Birth: _____

Address: _____

City: _____ ST:_____ Zip:_____

Phone: _____

Mainly for Moms:

Tell us about your pregnancy;

1. **Did you carry to full term? _____**
2. **Describe any complications and when they occurred:**
   _____
   _____
   _____
   _____

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

Did you use a midwife? _____ Obstetrician? _____

Homebirth? _____ Hospital? _____

Were you induced? _____ If yes,
Reason:_____
_____

Did you have a C-Section? _____If yes,

Reason: _____

Were forceps used? _____ _____Vacuum Extraction? _____

Did you have an Epidural? _____ Was it a difficult birth?_____

What was the APGAR Score? At Birth? _____ at 5 minutes? _____

4. **Tell us more:**

   a. **Did you breastfeed? _____ How long?**
      What formula after? _____

b. Did you consume alcohol during your pregnancy? _____How much? _____

c. Did you smoke? _____ How much? _____How long? _____

d. Did you take any medication during your pregnancy? _____For what? _____

What type? _____

e. Any exposures to ultrasound?_____, How many?_____

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

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

a. Please explain the above:

_____

_____

_____

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

____	**Fall from a tree**	**____**	**Bed wetting**
____	**Fall of a bicycle**	**____**	**Hyperactivity/Autism**
____	**Fall of playground equipment**	**____**	**Learning difficulties**
____	**Sports accident**	**____**	**Asthma**
____	**Car accident**	**____**	**Allergies**
____	**Stomach pains**	**____**	**Leg/knee pains**
____	**Scoliosis**	**____**	**Other_____**

a. Please explain the above:

_____

_____

_____

7. Tell us about any vaccinations your child has had: _____

_____

_____

Any reactions to any of these?

_____

Were you told that you had a choice in vaccinating your child? ____YES ____NO
Would you like information on the issue of vaccinations? ____YES ____NO

8. 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 pains**	**____ 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:

_____

_____

_____

a. **Which of the above issues have you checked is the worst? _____**

_____

Is this problem: Constant __, Intermittent __, Occasional __, Cyclic ____

b. **How long has it persisted? _____**

_____

c. **When it is at its worst, how does it make your child feel? _____**

d. **What have you tried it that has NOT helped? _____**

_____

_____

e. **What makes it worse? _____**

f. **What effect does this problem have on your child's body functions?**

_____

_____

g. **How does it affect his/her participation in daily activities?**

_____

h. **Describe any hospital stays:**

_____

_____

i. **Approximately how many times have antibiotics been prescribed for your child and for what conditions?**

_____

j. **List any medications your child is currently taking:**

_____

_____

k. **To summarize, what is your purpose for this appointment?**

_____

_____

_____

l. **Is there anything else you feel we should know?**

_____

_____

Signature of parent or guardian: _____

Date: _____

***

In compliance with requirements for the government EHR incentive program:

Preferred method of communication for patient reminders (Circle one): Email / Phone / Mail

DOB: __/__/____ **Gender (Circle one):** Male / Female **Preferred Language: _____**

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

CMS requires providers to report both race and ethnicity

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) Native Hawaiian or Pacific Islander / Other / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications? (Please include regularly used over the counter medications)

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

☐ **I choose to decline receipt of my clinical summary after every visit** *(These summaries are often blank as a result of the nature and frequency of chiropractic care.)*

Patient Signature: _____ Date:_____

Louisville Family Chiropractic
8117 New LaGrange Rd.
Louisville, KY 40222
Phone: 502-326-9950
health@lfchiro.net

Acknowledgement of Receipt of Privacy Notice

Purpose of this Acknowledgement

This Acknowledgement, which allows the Practice to use and/or disclosure personally identifiable health information for treatment, payment or healthcare operations, is made pursuant to the requirements of 45 CFR 164.520(c)(2)(ii), part of the federal privacy regulations for the Health Insurance Privacy and Accountability Act of 1996 (the "Privacy Regulations").

Please read the following information carefully:

1. I understand and acknowledge that I am consenting to the use and/or disclosure of personally identifiable health information about me by Louisville Family Chiropractic (the "Practice") for the purposes of treating me, obtaining payment for treatment of me, and as necessary in order to carry out any healthcare operations that are permitted in the Privacy Regulations.
2. I am aware that the Practice maintains a Privacy Notice which sets forth the types of uses and disclosures that the Practice is permitted to make under the Privacy Regulations and sets forth in detail the way in which the Practice will make such use or disclosure. By signing this Acknowledgement, I understand and acknowledge that I have received a copy of the Privacy Notice.
3. I understand and acknowledge that in its Privacy Notice, the Practice has reserved the right to change its Privacy Notice as it sees fit from time to time. If I wish to obtain a revised Privacy Notice, I need to send a written request for a revised Privacy Notice to the office of the Practice at the above address, Attention: Practice Compliance Director.
4. I understand and acknowledge that I have the right to request that the Practice restrict how my information is used or disclosed to carry out treatment, payment or healthcare operations. I understand and acknowledge that the Practice is not required to agree to restrictions requested by me, but if the Practice agrees to such a requested restriction it will be bound by that restriction until I notify it otherwise in writing. I request the following restrictions be placed on the Practice's use and/or disclosure of my health information (leave blank if no restrictions:_____

   I understand the foregoing provisions, and I wish to sign this Acknowledgement authorizing the use of my personally identifiable health information for the purposes of treatment, payment for treatment and healthcare operations. By signing this form, I acknowledge that I have reviewed an executed copy of this acknowledgement and a copy of the Practice's Policy Notice and agree to the Practice's use and disclosure of my protected health information for treatment, payment and health care operations.

_____ _____
Signature of Patient or Representative Date

_____ _____
Patient's Name (please print) Date of Birth

_____ _____
Name of Personal Representative Relationship to Patient

To Be Completed by the Practice
The requested restrictions on the use and/or disclosure of the patient's health information set forth above are:
___Accepted _____Denied ___ Not Applicable _____Other (explain)_____

_____
Signature of Authorized Practice Representative Date

LOUISVILLE FAMILY CHIROPRACTIC

Authorization, Assignment, Consent to Treat and Medical Release

In consideration of you undertaking to treat me, I agree to the following:

MEDICAL RELEASE

LFC is authorized to release any information deemed appropriate concerning my physical condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred by the patient. All charges incurred by the patient or dependents is the patients responsibility, if insurance does not pay, the patient is responsible for the balance.

ASSIGNMENT OF BENEFITS

I authorize the direct payment to you of any sum I now and hereafter owe you by my attorney out of proceeds of any settlement of my case, and by any insurance company obligated to make payment to me or you based in whole or in part upon the charges made for your services.

In the event any insurance company obligated by contractual agreement to make payment to me or to you for the charges made for your services refuses to make such payment upon demand by you, I hereby assign any such company (the pertinent data below) and authorize you to compromise, settle or otherwise resolve this claim as you see fit. However, it is understood that until all reasonable efforts have been made to collect the sums due from the insurance company (or companies) contractually obligated, you will understand that whatever amounts you do not collect from insurance proceeds (whether it be part or all of what is due), I personally owe to you.

AUTHORIZATION

I, the undersigned, do hereby appoint Louisville Family Chiropractic, and any of its duly authorized agents, to serve as lawful attorney invested with all powers and authority necessary to endorse and cash any checks, drafts or money orders which are made payable to the undersigned above or as co-payee with Louisville Family Chiropractic when said payments are due for services rendered on behalf of the undersigned by the clinic.

PREGNANCY RELEASE

This is to certify that to the best of my knowledge I am not pregnant and that Louisville Family Chiropractic doctor(s) and his/her associates have my permission to perform an x-ray examination. I have been advised that x-ray can be hazardous to an unborn child.
Date of last menstrual period ___/___/___. (initial _____)

CONSENT TO TREAT

I, the undersigned, do hereby authorize Louisville Family Chiropractic, (and whomever may be designated as assistants) to administer such examinations, treatments and care, as they deem necessary.

A photocopy of this assignment shall be valid and have the same effect as the original

_____

Date Patient's Signature Witness Signature

LOUISVILLE FAMILY CHIROPRACTIC

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustment of the spine.

Health: A state of optimal physical, mental, social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebrae in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any diseases or condition other than vertebral subluxation. However, it during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of another health care provider.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, _____, have read and fully understand the above statements.
(Patient's name)

_____ _____

Signature Date