CIRA
CHIROPRACTIC
& WELLNESS

Initial Child & Adolescent Questionnaire

Today's Date_____

Name _____ Age _____ Date of Birth _____

Gender ❑ M ❑ F Height _____ Weight _____

Home Address _____City _____ State _____ Zip _____

Names and Ages of Siblings_____

Parent A	Parent B
Name _____	Name _____
Home phone (_____) _____	Home phone (_____) _____
Mobile phone (_____) _____	Mobile phone (_____) _____
Employer _____	Employer _____
E-mail_____	E-mail_____

Whom may we thank for referring you to our office? _____

Mainly for Moms:

1. Tell us about your pregnancy:

Did you carry to full term?_____

Describe any complications and when they occurred: _____

_____

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

Did you use a midwife? _____ Hospital? _____ Obstetrician? _____

Did you have a C-Section? _____ Were forceps used? _____

Vacuum Extraction? _____ Were you induced? _____

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

What was the baby's APGAR Score? _____ at 5 minutes? _____

3. Tell us more:

Did you breastfeed? _____ How long? _____ What formula after?_____

Did you consume alcohol during your pregnancy? _____ How much? _____

Did you smoke? _____ How much? _____ How long? _____

Did you take any medication during your pregnancy? _____

For what?_____ What type? _____

Any exposures to ultrasound? _____ How many?_____

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

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

Please explain the above:_____

_____

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

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

Please explain the above: _____

_____

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

_____

Any reactions to any of these? _____

_____

7. As a child or adolescent, has your child experienced any of the following:

- ❑ Headaches
- ❑ Dizziness
- ❑ Ringing in ears
- ❑ Asthma
- ❑ Hyperactivity
- ❑ Fatigue
- ❑ Numbness in arms/hands
- ❑ Arm/wrist pains
- ❑ Sleeping problems
- ❑ Allergies
- ❑ Stomach problems
- ❑ Weight gain/loss
- ❑ Foot/ankle/knee pains
- ❑ Tingling in arms/legs
- ❑ Neck/back pains
- ❑ Shoulder pains
- ❑ "Growing Pains"
- ❑ Other _____

Please explain any of the above: _____

_____

8. Has your Child had a head injury or concussion?_____

Date of injury:_____

Please describe the injury_____

_____

Please check all that apply:

- ❑ Irritability or aggression
- ❑ Poor memory
- ❑ Poor word recall
- ❑ Anger, anxiety, depression
- ❑ Sleep disorders
- ❑ Speech difficulties
- ❑ Visual disturbance
- ❑ Apathy or lack of spontaneity
- ❑ Fatigue
- ❑ Brain fog
- ❑ Headache
- ❑ Nausea
- ❑ Tinnitus
- ❑ Speech problems

9. Which of the problems you have checked off is the worst? _____

Is this problem: Constant_____ Intermittent _____ Occasional _____Cyclic _____

10. How long has it persisted? _____

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

12. What have you done about it that has NOT worked? _____

_____

13. What makes it worse? _____

14. What effect does this problem have of your child's body functions? _____

_____

On his/her participation in daily activities? _____

_____

15. Describe any hospital stays: _____

_____

16. Approximately how many times have antibiotics been prescribed and for what conditions?

_____

17. List any medications your child is currently taking: _____

_____

18. What physical activity does your child participate in? _____

18. To summarize, what is your purpose for this appointment? _____

_____

20. Is there anything else you feel we should know? _____

_____

On a scale of 1 to 10, with 10 being the highest, rate your commitment in helping us solve this problem:_____

Has your child ever received chiropractic care? ❑ Y ❑ N Name of D.C. _____

Reason _____ How long? _____ Date of last visit _____

Why was care stopped? _____

Have you consulted or do you regularly consult any of the following providers for your child?

Check all that apply ❑ Medical Physician ❑ Naturopath ❑ Acupuncturist ❑ Homeopath
❑ Massage Therapist ❑ Psychotherapist ❑ Other

Reason _____

Payment in full is expected on all FIRST VISIT services (whether you have insurance coverage or not.) All other fees are to be paid at time of service until other arrangements have been made and agreed upon in writing.

Please indicate your method of payment. ❑ Cash ❑ Check ❑ Credit Card

First Visit Fees: Comprehensive Exam:$175 time of service fee
$270-350 customary fee

INSURANCE INFORMATION

Insurance coverage varies greatly. We cannot predict whether your policy will cover the services we provide in our office. It is your responsibility to contact your insurance company to determine the amount and extent of coverage.
Please indicate below the type and name of your Insurance**

If you have coverage, our staff will need a copy of your insurance card.

Insurance type: ❑ Medicare ❑ Auto Accident ❑ Workers Comp. ❑ Other (e.g., Aetna, Cigna, Blue Shield, etc.)

Insurance name:_____

Is this an Auto Accident or a Work-Related Injury? ❑ Yes ❑ No

If **yes**, please provide us with the following information:

Have you been treated elsewhere? ❑ Yes ❑ No

If **yes**, where? ❑ Emergency Room ❑ Primary Care ❑ Other _____

What services were provided? ❑ MRI ❑X-Rays ❑ Medication ❑ Therapy ❑ Other

(details)_____

Patient Name: (Printed) _____

Signature _____ Date: _____

PLEASE READ AND SIGN

1. I have been informed that a copy of Cira Chiropractic's *"Notice of Privacy Practices for Protected Health Information (HIPAA)"* brochure is available for my review both in the office and on the website at www.cirachiropractic.com.

2. I consent to receive communication from Cira Chiropractic via email, postal mail, text and telephone messaging in connection with my care. ❑ Yes ❑ No If I should withdraw my consent, I will notify the office in writing.

3. I clearly understand and agree that all services rendered are ultimately charged directly to me and that I am personally responsible for payment. I agree that I am responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand that if my care is suspended or terminated, any fees for professional services rendered will become immediately due and payable.

4. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and policyholder. I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in collecting from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt. I hereby authorize assignment of insurance rights and benefits (if applicable) directly to the provider for services rendered to myself.

The information I have provided on this case history form is true and accurate to the best of my knowledge.
I give Dr. Cathy Cira permission to render care to myself today. This initial visit includes a health history consultation, chiropractic exam and evaluation, and any initial care that is determined to be clinically necessary and mutually agreed upon.

Patient Name: (Printed) _____

Signature _____ Date: _____

Thank you for choosing Cira Chiropractic and Wellness