

PEDIATRIC HISTORY FORM

Dear New Patient,

It is a pleasure to welcome you to our family of happy and healthy chiropractic patients. Please let us know if there is any way we can make you and your family feel more comfortable. To help us serve you better, please complete the following information. We look forward to working with you to build better health for your family.

Patient Name: _____ S.S.#: _____

Address: _____ City: _____

State: _____ Zip: _____ Referred By: _____

Sex: _____ Weight: _____ Height: _____ Birth Date: _____ / _____ / _____

Names of Parents / Guardians: _____

Purpose For Contacting Us? _____

Other Doctors Seen for this Condition: _____ N _____ Y, Doctor's Names and Prior Treatments: _____

Other Health Problems? _____

Check any of the Following Conditions Your Child has Suffered from During the Past Six Months:

- | | | | | |
|---------------------------------------------|---------------------------------------------|---------------------------------------|-------------------------------------------|-----------------------------------------------|
| <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Seizures | <input type="checkbox"/> Chronic Colds | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Asthma / Allergies | <input type="checkbox"/> Digestive Problems | <input type="checkbox"/> ADHD | <input type="checkbox"/> Recurring Fevers | <input type="checkbox"/> Growing / Back Pains |
| <input type="checkbox"/> Colic | <input type="checkbox"/> Bed Wetting | <input type="checkbox"/> Car Accident | <input type="checkbox"/> Temper Tantrums | <input type="checkbox"/> Other: _____ |

Family History: _____

Previous Chiropractor: _____

Date of Last Visit: _____ / _____ / _____ Reason: _____

Name of Pediatrician: _____

Date of Last Visit: _____ / _____ / _____ Reason: _____

Are You Satisfied with the Care Your Child has Received There? _____ N _____ Y

Number of Doses of Antibiotics Your Child has Taken:

During the Past Six Months: _____, Total During His / Her Lifetime: _____

Number of Doses of Other Prescription Medications Your Child has Taken:

During the Past Six Months: _____, Total During His / Her Lifetime: _____ List: _____

Vaccination History: _____

Prenatal History:

Name of Obstetrician / Midwife: _____

Complications During Pregnancy? _____ N _____ Y, List: _____

Ultrasounds During Pregnancy? _____ N _____ Y, Number: _____

Medications During Pregnancy / Delivery? _____ N _____ Y, List: _____

Cigarette / Alcohol Use During Pregnancy: _____ N _____ Y

Location of Birth: _____ Hospital _____ Birthing Center _____ Home

Birth Intervention: _____ Forceps _____ Vacuum Extraction
_____ Caesarian Section, Emergency or Planned?

Complications During Delivery? _____ N _____ Y, List: _____

Genetic Disorders or Disabilities _____ N _____ Y, List: _____

Birth Weight: _____ Birth Length: _____ APGAR Scores: _____, _____

Feeding History:

Breast Fed: _____ N _____ Y, How Long: _____

Formula Fed: _____ N _____ Y, How Long: _____ Type: _____

Introduced to Solids at: _____ Months, Cows' Milk at _____ Months

Food / Juice Allergies or Intolerances: _____ N _____ Y, List: _____

Development History:

During the following times your child's spine is most vulnerable to stress and should routinely be checked by a doctor of chiropractic for prevention and early detection of vertebral subluxations (spinal nerve interference). At what age was your child able to:

_____ Respond to Sound	_____ Cross Crawl
_____ Respond to Visual Stimuli	_____ Stand Alone
_____ Hold Head Up	_____ Walk Alone
_____ Sit Up	

According to the National Safety Council, approximately 50% of children fall head first from a high place during their first year of life (i.e., a bed, changing table, down stairs, etc.) Was this the case with your child? _____ N _____ Y

Is / has your child been involved in any high impact or contact type sports (i.e., Soccer, Football, Gymnastics, Baseball, Cheerleading, Martial Arts, etc.) ? _____ N _____ Y, List: _____

Has Your Child Ever Been Involved in a Car Accident? _____ N _____ Y, List: _____

Has Your Child Been Seen on an Emergency Basis? _____ N _____ Y, List: _____

Other Traumas Not Described Above? _____ N _____ Y, List: _____

Prior Surgery: _____ N _____ Y, List: _____

Menarche: _____ N _____ Y, Age: _____

Childhood Diseases:

Chicken Pox	N / Y, Age: _____	Mumps	N / Y, Age: _____
Rubella	N / Y, Age: _____	Whooping Cough	N / Y, Age: _____
Rubeola	N / Y, Age: _____	Other	N / Y, Age: _____

**WE ARE HERE TO SERVE YOU, AND ENCOURAGE YOU TO ASK QUESTIONS.
YOUR PARTICIPATION IS VITAL AND WILL HELP DETERMINE YOUR RESULTS.
AUTHORIZATION FOR CARE OF MINOR**

I hereby authorize this office and its Doctors to administer care to my Son / Daughter as they deem necessary. I clearly understand and agree that I am personally responsible for payment of all fees charged by this office.

Name of Insurance Company: _____ Policy #: _____

Signed: _____ Witnessed: _____ Date: _____ / _____ / _____

Coniglio Chiropractic & Wellness

INFORMED CONSENT FORM

I hereby request and consent to the performance of chiropractic adjustments and other professional procedures, including various modes of physio-therapy, acupuncture and diagnostic services, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic and/or the preceptor and/or other licensed professionals who now or in the future treat me while employed by, working or associated with, or serving as backup for the doctor named below, including those working at the clinic or office listed below or any other office or clinic.

Chiropractic treatment involves the science, philosophy, and art of locating and correcting spinal misalignments and as such, is oriented toward improvement of spinal function relative to range of motion, muscular and neurological aspects. There has been no promise, implied or otherwise, of a cure for any symptom, disease or condition as a result of treatment in this clinic. I understand that the chiropractor will use their hands or a mechanical device upon my body to adjust a joint, which may cause an audible "pop" or "click". It is my intention to rely on the doctor to exercise professional judgment during the course of any procedures, which they feel at the time to be in my best interest. Neither the practice of chiropractic or medicine is an exact science, but relies upon information related by the patient, information gathered during examination, and the doctor's interpretation thereof, as well as the doctor's judgment and expertise in working with like cases.

I understand that as part of my healthcare, this Practice originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, and treatment, and any plans for future care or treatment. I understand that this information serves as a basis for planning my care and treatment; a means of communication among other health professionals who may contribute to my care; a source of information for applying my diagnosis and treatment information to my bill; and a means by which a third-party payer can verify that services billed were actually provided.

I have had the opportunity to discuss with the doctor and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand and am informed that, as in the practice of medicine, in the practice of chiropractic, there are some risks of treatment including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. It is not reasonable to expect the doctor to be able to anticipate and explain all risks and complications of a given procedure on any particular visit, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the Practice reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I have provided or forward a copy via email at my request. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the Practice is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the Practice has already taken action in reliance thereon.

I have read, or have had read to me, the Informed Consent to Chiropractic Adjustments and Professional Care. I have also had an opportunity to ask questions about its consent, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Name (printed)

Date Signed

Signature: Patient or Legal Representative (Attorney, Guardian, Parent)

Witness to Patient's Signature

OFFICE POLICY REGARDING INSURANCE ASSIGNMENT, SELF-PAYING AND APPOINTMENT SCHEDULING

Coniglio Chiropractic & Wellness is pleased to accept your insurance assignment, as soon as the responsible party verifies your exact coverage. We will file forms to assist you in every way we can. It must be fully understood that the contract is between you and your insurance company. You are fully responsible for any amount that is not paid by your insurance.

1. **You are required to sign an “Authorization to Pay Physician” form and any other** assignment documents required by your insurance company on your first visit.
2. **Our office does not guarantee that your insurance will pay.** We will make every attempt, at the beginning of your health care, to receive verification of your policy and what it covers. However, if for some reason, your insurance claim is denied, you are responsible for the full amount.
3. Our office will ***NOT*** enter into a dispute with your insurance company over your claim. This is your responsibility and obligation. If circumstance warrants, your insurance assignment may be withdrawn.
4. You are required to pay the percentage of your responsibility as you go along. (E.g. if your insurance pays 80% of your care, you pay 20% on each visit).
5. Any insurance balance over 60 days past due is subject to late payment penalties at 1.5% per month.
6. I agree to pay any collection and/or attorney fees that may arise as a result of any unpaid balance being forwarded to a collection agency and/or attorney to cause payment.
7. All returned checks are subject to a \$25 service fee and a late payment fee (see below).
8. A late payment fee will be assessed if payment on balance is not received by the 10th of the month.
9. Late Payment Fee: \$15 if the balance is \$0 - \$99; \$25 if the balance is \$100 - \$999.99; and \$35 if the balance is \$1000 or more. (Balance means Previous Balance on Statement that shows the Late Fee.)
10. A \$30.00 fee will be charged if an appointment is missed without prior rescheduling.
11. For your health this is a Smoke-Free property.
12. I have read and understand the above office policy and agree to its terms.

SIGNATURE OF PATIENT/GUARDIAN

DATE

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Coniglio Chiropractic & Wellness
1144 Mantua Pike
Mantua, NJ 08051

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (“HIPAA”), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice Of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Private Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

OFFICE USE ONLY

I attempted to obtain the patient’s signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason:
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Child Neurotransmitter & Nutrition Questionnaire (CNNQ)

Name: _____ Age: _____ Sex: _____ Date: _____

* Please circle the appropriate number "0 - 3" on all questions below. 0 as the least/never to 3 as the most/always.

SECTION: GENERAL

- Does your child have any food sensitivities or allergies? (please list)

- List your child's 4 healthiest foods eaten regularly.

_____, _____,

- List your child's 4 unhealthiest foods eaten regularly.

_____, _____,

- How many times a week does your child eat candy? _____

- How many times a week does your child drink soda pop? _____

- Please list the top 4 foods your child craves regularly?

_____, _____,

- List the medication(s) your child is currently prescribed and over the counter.

- Do you find it difficult as a parent to have your child on a special diet?

SECTION: A (K52)

- Does your child eat pasta, breads, and breaded foods? 0 1 2 3

- Does your child have symptoms (fatigue, hyperactivity, etc.) after eating wheat foods? 0 1 2 3

- Does your child eat dairy products? 0 1 2 3

- Does your child have symptoms (fatigue, hyperactivity, etc.) after eating dairy products? 0 1 2 3

SECTION: B (K53)

- Does your child eat fried fish? 0 1 2 3

- Does your child eat roasted nuts or seeds? 0 1 2 3

- Is your child **missing** essential fatty acid rich foods in his/her diet? (for example: avocados, flax seeds, olives) (mark "0" if present, "3" if missing) 0 1 2 3

- Does your child eat *fried* foods? 0 1 2 3

SECTION: C (K34)

- Is your child's mental speed slow? 0 1 2 3

- Does your child have difficulty with learning or memory? 0 1 2 3

- Does your child have difficulty with balance and coordination? 0 1 2 3

SECTION: D (K16)

- Does your child have stress? 0 1 2 3

- Does your child **not** have enough sleep and rest? (mark "3" if not enough) 0 1 2 3

- Does your child **not** have regular exercise? (mark "3" if no exercise) 0 1 2 3

- Does your child feel overly worried and scared? 0 1 2 3

SECTION: E (K16, K51)

- Does your child have temper tantrums? 0 1 2 3

- Does your child exhibit wild behavior? 0 1 2 3

- Does your child frequently yell or scream for unnecessary reasons? 0 1 2 3

- Does your child have an **inability** to nap or sleep when physically exhausted? (mark "3" if unable) 0 1 2 3

- Is your child overly talkative? 0 1 2 3

- Does your child fidget and squirm when seated? 0 1 2 3

- Does your child run and climb excessively when it is inappropriate? 0 1 2 3

- Does your child have difficulty playing quietly or engaging in leisure activities? 0 1 2 3

SECTION: F (K51)

- Does your child get excited easily? 0 1 2 3

- Does your child have anxiousness and panic for minor reasons? 0 1 2 3

- Does your child feel overwhelmed for minor reasons? 0 1 2 3

- Does your child find it difficult to relax when she/he is awake? 0 1 2 3

- Does your child have disorganized attention? 0 1 2 3

SECTION: G (K50)

- Does your child seem depressed? 0 1 2 3

- Does your child have mood changes with overcast weather? 0 1 2 3

- Does your child have symptoms of inner rage? 0 1 2 3

- Does your child seem uninterested in games or hobbies? 0 1 2 3

- Does your child have difficulty falling into deep restful sleep? 0 1 2 3

- Does your child seem uninterested in friendships? 0 1 2 3

- Does your child have symptoms of unprovoked anger? 0 1 2 3

- Does your child seem uninterested in eating? 0 1 2 3

SECTION: H (K49)

- Does your child have difficulty handling stress? 0 1 2 3

- Does your child have anger and aggression while being challenged? 0 1 2 3

- Does your child feel tired even after long sleeps? 0 1 2 3

- Does your child tend to isolate from others? 0 1 2 3

- Does your child get distracted easily? 0 1 2 3

- Does your child have constant need and desire for candy and sugar? 0 1 2 3

- Does your child have disorganized attention? 0 1 2 3

SECTION: I (K48)

- Does your child have difficulty with visual memory? 0 1 2 3

- Does your child have difficulty remembering locations? 0 1 2 3

- Does your child have fatigue or low endurance for learning activities? 0 1 2 3

- Does your child have difficulty with attention or low attention span or endurance? 0 1 2 3

- Does your child have slow or difficult speech? 0 1 2 3

- Does your child have uncoordinated or slow movement? 0 1 2 3

Symptom groups listed in this flyer are not intended to be used as a diagnosis of any disease condition. For nutritional purposes only