24610 Highway 17
Waynesville, MO 65583
Ph: 573-774-4177
Fax: 573-774-3921
www.oglechiropractic.com

Pediatric Patient Questionnaire

1. CONFIDENTIAL PATIENT INFORMATEON:

Child's Name: _____ Date of Birth: _____ Gender: _____

Parent/Guardian Name(s): _____ Child's Social Security#: _____

Street Address: Apt./Unit #: City: State: Zip Code:

_____

Cell Phone: Home Phone: Work Phone:

_____

Email: _____ Height: _____ Weight: _____

Who is your primary care physician?

_____

2. How did you hear about us? (please select a!! that app\y & list who in the box that appears)

r Current Patient (list who) _____

r Professional Referral/Doctor (list who) _____

r Google Search _____

r Facebook _____

r Community Partner (list who) _____

or Other (specify) _____

Is your child receiving care from any other health professionals?

- ☐ Yes
- ☐ No

3. If yes, please name them and their specialty:

	Name	Specialty
1		
2		
3		

Others:

_____

4. Please list any drugs/medications/vitamins/herbs/other that your child is taking:

	Medication Name	Dosage	Frequency	Reason for Taking
2				
3				

Others:

_____

CURRENT HEALTH CONDITIONS

6. What are the primary health concerns for your child?

7. Please describe when your child's issues first began and how they've progressed since:

8. What makes things better?

9. What makes things worse?

HEALTH GOALS FOR YOUR CHILD

10. What are your top three health goals for your child:

_____

_____

2.

_____

_____

3.

_____

_____

1 1. What would you like to gain from chiropractic care?

- Resolve existing condition Overall wellness + prevention r Both

12. Have you ever visited a chiropractor?

- Yes
- No

If yes, what is their name:

_____

13. What is their specialty?

- r Pain Relief
- Nutritional
- Other
- r Physical Therapy & Rehab
- r Subluxation-based

If other, specify:

_____

PREGNANCY & FERTILITY HISTORY

Please tell us about your pregnancy.

14. Any fertility challenges?

- Yes
- No

15. If yes, please explain:

_____

_____

_____

_____

16. Did mother smoke?

- Yes
- No

If yes, how many per week?

_____

17. Did mother drink?

- Yes
- No

If yes, how many per week?

_____

1 8. Did mother exercise?

- Yes
- No

19. If yes, please explain:

_____

_____

_____

_____

20. Was mother ill?

- Yes
- No

21. If yes, please explain:

22. Any ultrasounds?

- Yes
- No

23. If yes, please explain:

24. Please explain any notable episodes of emotional or physical stress during your pregnancy:

25. Please explain any other concerns or notable remarks about your child's conception or pregnancy:

LABOR & DELIVERY HISTORY

26. Child's birth was:

r Vaginal Birth Scheduled C-section Emergency C-section

At how many week's was your child born?

_____

27. Child's birth was:

r At home At a birthing center r At a hospital Other

If other, specify:

_____

28. Birth Provider's Name:

_____

29. Please check any applicable interventions or complications:

r Breech r Induction r Pain meds

r Manual assistance r Epidural r Episiotomy

r Vacuum extraction r Forceps r Cord-wrapped

r None of the above

If other, specify:

_____

30. Please describe any other concerns or notable remarks about your child's labor and/or delivery.

_____

_____

_____

_____

31. Child's birth weight: _____ Child's birth height: _____ APGAR score at birth: _____ APGAR score at 5 minutes: _____

GROWTH & DEVELOPMENT HISTORY

32. Is/was your child breastfed?

- Yes
- No

If yes, how long?

_____

33. Difficulty with breastfeeding?

- Yes
- No

If yes, is there a certain side that is more difficult for them?

_____

34. Did they ever use formula?

- Yes
- No

35. If yes:

At what age:

_____

36. Did/does your child ever suffer from colic, reflux, skin issues, or constipation as an infant?

- Yes
- No

37. If yes, please explain:

_____

_____

_____

38. Did/does your child frequently arch their neck/back, feel stiff, or bang their head?

- Yes
- No

39. If yes, please explain:

_____

40. At what age did the child:

	Age
Respond to sound:	
Follow an object:	
Hold their head up:	
Vocalize:	
Teething:	
Sit alone:	
Crawl:	
Walk:	
Begin cow's milk:	
Begin solid foods:	

41. Please list any food intolerance or allergies, and when they began:

	Food intolerance / Allergy	When they began
2		
3		

42. Please list your child's hospitalization and surgical history, including the year:

	Hospitalization / Surgery	Year
1		
2		
3		

43. Please list any major injuries, accidents, falls and/or fractures your child has sustained in his/her lifetime, including the year:

	Injury	Year
2		
3		

44. Have you chosen to vaccinate your child?

- Yes
- No

45. If yes, please list any vaccination reactions:

_____

_____

_____

46. Has your child received any antibiotics?

- Yes
- No

47. If yes, how many times and list reason:

_____

_____

_____

48. Any difficulty with bonding or social development?

- Yes
- No

49. If yes, please explain:

_____

_____

_____

50. Night terrors or difficulty sleeping?
    - Yes
    - No
51. If yes, please explain:

    _____

    _____

    _____

52. Behavioral, social or emotional issues?
    - Yes
    - No
53. If yes, please explain:

    _____

    _____

    _____

54. How many hours per day does your child typically spend watching TV, computers, tablet or phone?

    _____

55. How would you describe your child's diet?

    _____
    _____
    _____
    _____

56. Are there other health concerns, or is there anything else you'd like us to know about your child?

    _____

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.

57.

	Past	Present
Colic & Excessive Crying		
Difficulty Latching / Nursing		
Reflux & Excessive Spit Up		
Projectile Vomiting		
Frequent Stiffening, Rigidity, Arching		
Difficulty Sleeping		
Torticollis		
Plagiocephaly		
Motor Milestone Delays		
Low Tone & Coordination Challenges		
Speech & Communication Delays		
Sensory Processing Challenges		
Social / Emotional Challenges		
Frequent Tantrums & Meltdowns		
Behavior Issues		
Hyperactivity & Impulsivity		
Anxiety & Emotional Instability		
ADHD / ADD		
Balance & Coordination Issues		
Visual & Auditory Processing Challenges		
Handwriting & Fine Motor Challenges		
Low Energy and Fatigue		

	Past	Present
Depression & Lack of Confidence		
Lightheadedness & Dizziness		
Frequent Naseau & Malaise		
Headaches & Migraines		
Stick Neck & Shoulders		
Jaw, Swallowing, Sensory Food Aversions		
Vision & Hearing Issues		
Ear & Sinus Infections		
Sore Throat and Strep		
Swollen Tonsiles & Adenoids		
Strep & Upper Respiratory Infections		
Allergies and Autoimmune Challenges		
Chronic Inflammation		
Poor Metabolism & Weight Control		
Chronic Chest Colds & Cough		
Bronchitis & Pneumonia		

Asthma		
Blood Sugar Problems		
Skin Conditions / Rash		
Ulcerative Colitis, Crohn's, IBS		
Kidney Challenges		
Gas Pain & Bloating		
Gluten & Casein Intolerance		
Constipation		
Bladder & Urination Issues		
Hormonal Challenges		

	Past	Present
Low Back Pain & Stiffness		
Lumbopelvic / Sl Joint Pain		
Tight Hamstrings & Calves		
Toe Walking		
Poor Circulation & Cold Feet		
Weak Ankles & Arches		

ACKNOWLEDGEMENT & CONSENT

Patient or Parent/Guardian: _____

Signature: _____ Date: _____

OGLE CHIROPRACTIC & REHAB CENTER, LLC

24610 Highway 17, Waynesville, MO 65583
573-774-4177

Consent to use PHI

Acknowledgement for Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of your Protected Health Information

Your Protected Health Information will be used by **Ogle Chiropractic & Rehab Center, LLC** or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Please list those whom we may give your information to:

Name: _____ Phone#: _____

Q Name: _____ Phone#: _____

Name: _____ Phone#: _____

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office.

I have received a copy of the Notice of Patient Privacy Policy _____ Patient Initials

Requesting a Restriction on the Use or Disclosure of Your Information

You may request a restriction on the use or disclosure of your Protected Health Information. This office may or may not agree to restrict the use or disclosure of your Protected Health Information. If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Notice of Treatment in Open or Common Areas

Note that some of your treatment may be performed in an "open area". Private areas are available upon request to discuss your health information upon request. _____ Patient Initials

Revocation of Consent

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing- Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

With my signature below I give my permission to use and disclose my health information.

_____

Patient or Legally Authorized Individual Signature Date:

_____

Print Patients Full Name Time

_____

Witness Signature Date

Office Fee Schedule and Financial Policy

Service	Charges
Consultation	N/C
Initial Exam (Required)	$120
Progress Report	$80
X-Rays (per set) 2 views min.	$75
Adjustment	$40
Acupuncture	$45
Spinal Decompression	$50 per session
E-Stim	$15
Cupping	$20
Intersegmental Traction (Roller) Table	$15
Ultrasound	$25
B 12 Injection	$25 each
IMR Mat	$25
Diathermy	$15
ART (Active Release Technique)	$30
No Call/No Show Fee	$25

Financial Policy and Chiropractic Treatment Plans

Our responsibilities: We are committed to providing you with the best chiropractic care possible in a caring environment and have established our financial policies to achieve that goal. We will provide you the best service possible to meet your needs. We will correct any errors we have made if there is a dispute. We are available to answer any questions and will do our best to serve you in a polite and courteous manner. We will provide you a superbill at your request. We accept cash, credit/debit, and checks for payment of services rendered on each day. NOTE: There will be a returned check fee assessed if one is received.

Your responsibilities: Payment is expected at time of service unless you arrange a payment plan set up between you and the doctor. Know your insurance carriers' requirements for filing insurance claims. Every insurance carrier is different. We will verify your insurance coverage for you, however, remember your agreement with your insurance company is between you and them. Please contact the member services telephone number on the back of your card for more information. The information given by your insurance company is not a guarantee of coverage.

Cancellations: Please make any cancellations with at least 24 hours' notice or you will be billed a $25 no call/no show fee.

Collections: I fully understand that I am financially responsible for and agree to pay all charges. In consideration of the chiropractic services furnished to me, I hereby agree to pay Ogle Chiropractic and Rehab Center, LLC any balance due within sixty days from presentation of my bill. In the event of default, I promise to pay legal interest on Indebtedness together with 50% collection costs and attorney fees as may be required to effect collections.

Prices are subject to change at any time
I have read and I understand the above policy.

Patient Signature _____ Date_____

OGLE CHIROPRACTIC

INSURANCE DISCLOSURE

Our practice is committed to providing the best care possible and because of that, we would like to inform you our office does not accept any insurance. This decision has been made to ensure we can continue to deliver the highest quality care without the limitations often imposed by insurance companies.

We are unable to accept any new patients who are covered under Medicare. If a patient chooses not to disclose or is dishonest about having Medicare coverage, any financial responsibilities or issues that arise will fall solely on the patient.

All services will be provided on a self-pay basis, and payment will be due at the time of your appointment.

Patient Signature: _____

Date: _____

CONSENT TO CHIROPRACTIC EXAMINATION AND CARE

I hereby authorize **Ogle Chiropractic and Rehab Center, LLC** and its licensed doctors and assistants, based on my complaints and the history I have provided, to undertake an examination and provide an evaluation and treatment which may include chiropractic adjustments and other tests and procedures considered therapeutically appropriate. I also with to rely on the practice doctors to make those decisions about my care, based on the facts then known, that they believe are in my best interest.

The nature and purpose of the chiropractic examination and evaluation, the chiropractic adjustments and the other procedures that may be recommended during the course of my care have been explained and described to my satisfaction.

By signing below I acknowledge my consent to be examined:

The specifics of the doctor's recommendation will be further explained during a Report of Findings following your examination and any subsequent examinations and significant changes in your diagnosis or treatment/treatment plan. Based on current findings, practice doctors have discussed my diagnosis and treatment plan, the benefits and expected improvement with the proposed treatment and the reasonable alternatives to the proposed treatment. They have also explained the cost of my proposed care (or provided me with a current fee schedule) and to the extent practicable the costs of reasonable alternatives to the proposed treatment.

To aid the understanding of my condition and the reasons for the proposed course of care, the practice has provided me with the specific pamphlets and other literature and practice doctors have answered my questions regarding the planned treatments and course of care that I will receive. Practice doctors have also explained that my diagnosis and treatments may change during the course of care and that they will advise me of material changes in my diagnosis and treatment options and answer any additional questions that I may have at any time.

I have also been advised that although the incidence of complications associated with chiropractic services is very low, anyone undergoing adjusting or manipulative procedures should know of rare possible hazards and complications which may be encountered or result during the course of care. These include, but are not limited to, fractures, disk injuries, strokes, dislocations, sprains, and those which relate to physical aberrations unknown or reasonably undetectable by the doctor.

I understand and accept that:

1. I have the right to withdraw from or discontinue treatment at any time and that the Practice doctors will advise me of any material risks in this regard.
2. That neither the practice of chiropractic nor medicine is an exact science and that my care may involve the making of judgments based upon the facts known to the doctor during the course of my care.
3. That it is not reasonable to expect the doctor to be able to anticipate or explain all risks and complications or an undesirable result does not necessarily indicate an error in judgment or treatment.
4. The Practice does not guarantee as to results with respect any course of care or treatment.
5. My care and treatment will not be observed or recorded for any non-therapeutic purpose without my consent.

I have read this Consent (or have had it read to me) and have also had an opportunity to ask questions about the Consent and understand to my satisfaction the care and treatment I may receive. My signature below acknowledges my consent to the examination, evaluation and purposed course of care and treatments by the Practice.

_____ _____/_____

Patient's Printed Name Patient's Signature Date

Patient counseled by:_____

Signature of doctor

OGLE CHIROPRACTIC PHOTO RELEASE

I, on behalf of myself and/or my minor children, hereby grant **Ogle Chiropractic, LLC**, (OC) and its officers, chiropractors, owners and employees the right to take photographs of myself and my minor child(ren), while on the premises of OC or while attending any offsite event hosted or otherwise sponsored by OC or any of OC's affiliate businesses. I further give permission for the use of such photographs in the advertising, business, web-hosted, social media account, or educational materials promulgated, created, designed, purchased or otherwise used by OC for purposes of promoting OC. I hereby waive any applicable right of privacy that I may assert on behalf of myself or my minor child(ren), and further agree that such photos may be used for any additional lawful purposes related to promoting OC and it's affiliates as well as chiropractic treatment in general. To the extent that such disclosures show a doctor/patient relationship, I hereby waive such privilege on behalf of myself and my minor child(ren) for the limit purposes enumerated herein specifically related to photographic material.

I have fully read and understand the implications of this wavier and release and hereby affix my signature in acknowledgment of my agreement with such terms. By affixing my signature below, I am also confirming that I am at least 18 years of age, or, if signing on behalf of a minor child, that I am at least 18 years of age.

I am at least 18 years of age and have read and understand the above:

Patient Name: _____

If under 18 years of age the legal guardian or parent has read and understands the above:

Parent/Guardian Name:

_____

_____ _____

Patient Signature Date