Your Chiropractic Wellness Studio
Chiropractic • Massage • Weight loss • Nutrition

PO Box 2048 Chico, CA 95927 (530) 846-6262

Initial Child & Adolescent Questionnaire

Child's Name: _____, Mom: _____

Date of Birth: _____ Dad: _____

Address: _____ Primary Phone: _____

_____ Secondary Phone: _____

Tell us about your pregnancy;

Did you carry to full term? _____

Describe any complications and when they occurred: _____

Was it a difficult birth for this child? :

Did you have a C-Section? ____ Were forceps used? _____Vacuum Extraction?__
Were you induced? _____

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 a Jolly Jumper
___ Frequent ear infections
___ Tonsilitis
___ 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: _____
_____
_____

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

___ Fall from a tree
___ Fall of a bicycle
___ Fall of 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: _____
_____
_____

Which of the problems you have checked off is the worst? _____ _____
Is this problem: Constant __, Intermittent __, Occasional __, Cyclic __

How long has it persisted? _____
When it is at its worst, how does it make your child feel? _____
What have you done about it that has NOT worked? _____
_____

_____
What makes it worse? _____
What effect does this problem have of your child's body functions?
_____
_____
On his/her participation in daily activities? _____
Describe any hospital stays: _____
_____

Approximately how many times have antibiotics been prescribed and for what conditions? _____
_____
List any medications your child is currently taking: _____
_____

To summarize, what is your purpose for this appointment? _____
_____
_____
Is there anything else you feel we should know? _____
_____

Signature of parent or guardian: _____

Date: _____

CONSENT TO TREAT A MINOR

Rabo Health and Wellness

I (We) being the parent or guardian

of_____, a minor, the age

of_____years old, do hereby consent, authorize and request Dr. Rabo to administer such treatment deemed advisable, necessary or requested on the above minor.

Child's date of birth:_____

I (We) agree to hold him and Rabo Chiropractic Center free and harmless from any claims, suits for damages or complications which may result from such treatment.

Signed Parent/Guardian

#1_____

#2_____

Date:_____

ACKNOWLEDGMENT OF RECIEPT OF NOTICE OF PRIVACY PRACTICES OF RABO HEALTH AND WELLNESS

I herby acknowledge that I have been provided for review a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I will be offered a copy of any amended Notice of Privacy Practices in the future.

Rabo health and Wellness may mail to my home or other designated location any items that assist them in carrying out treatment, payment, and health care operations, such as appointment reminders, and billing items and laboratory results, among others, relating to my care.

(Please Initial) _____ Yes _____ No

Rabo Health and Wellness may call my home or other designated location and leave a message or voicemail in reference to any items that assist them in carrying out treatment payment and healthcare operations, such as appointment reminders, insurance and billing items and laboratory results, among others, relating to my care.

(Please Initial) _____ Yes _____ No

I understand that I may revoke the above consent at any time in the future in writing.

Signed _____ Print _____ Date _____