Pediatric Patient Questionnaire

CONFIDENTIAL PATIENT INFORMATION

Child's Name: Parent/Guardian Name(s):

Street Address: City: State: Zip:

Cell Phone: Home Phone: Work Phone:

Email: Child's SS #: - - Birthdate: / / Age:

How did you hear about us? Height: ft. in. Weight: lbs.

Who is your primary care physician?

Is your child receiving care from any other health professionals? ◯ Yes ◯ No
- If yes, please name them and their specialty:

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

CURRENT HEALTH CONDITIONS

What health condition(s) bring your child to be evaluated by a chiropractor?

When did the condition first begin? How did the problem start? ◯ Suddenly ◯ Gradually ◯ Post-Injury

Has your child ever received care for this condition before? ◯ Yes ◯ No
- If yes, please explain:

Is this condition: ◯ Getting worse ◯ Improving ◯ Intermittent ◯ Constant ◯ Unsure

What makes the problem better? What makes the problem worse?

HEALTH GOALS FOR YOUR CHILD

What are your top three health goals for your child:

1. _____
2. _____
3. _____

What would you like to gain from chiropractic care?

◯ Resolve existing condition
◯ Overall wellness
◯ Both

Have you ever visited a chiropractor? ◯ Yes ◯ No If yes, what is their name?

What is their specialty? ◯ Pain Relief ◯ Physical Therapy & Rehab ◯ Nutritional ◯ Subluxation-based ◯ Other:

PREGNANCY & FERTILITY HISTORY

Please tell us about your pregnancy

Any fertility issues? ◯ Yes ◯ No If yes, please explain: _____

Did mother smoke? ◯ Yes ◯ No If yes, how many per week? _____

Did mother drink? ◯ Yes ◯ No If yes, how many per week? _____

Did mother exercise? ◯ Yes ◯ No If yes, please explain: _____

Was mother ill? ◯ Yes ◯ No If yes, please explain: _____

Any ultrasounds? ◯ Yes ◯ No If yes, please explain: _____

Please explain any notable episodes of mental or physical stress during your pregnancy:

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

LABOR & DELIVERY HISTORY

Child's birth was: ◯ Natural vaginal birth ◯ Scheduled C-section ◯ Emergency C-section At how many week's was your child born?

Child's birth was: ◯ At home ◯ At a birthing center ◯ At a hospital ◯ Other: Doctor/Obstetrician's Name:

Please check any applicable interventions or complications:

◯ Breech ◯ Induction ◯ Pain meds ◯ Epidural ◯ Episiotomy ◯ Vacuum extraction ◯ Forceps ◯ Other

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

Child's birth weight: lbs. oz. Child's birth height: in. APGAR score at birth: APGAR score after 5 minutes:

GROWTH & DEVELOPMENT HISTORY

Is/was your child breastfed? ◯ Yes ◯ No If yes, how long? Difficulty with breastfeeding? ◯ Yes ◯ No

Did they ever use formula? ◯ Yes ◯ No If yes, at what age? If yes, what type?

Did/does your child ever suffer from colic, reflux, or constipation as an infant? ◯ Yes ◯ No
- If yes, please explain:

Did/does your child frequently arch their neck/back, feel stiff, or bang their head? ◯ Yes ◯ No
- If yes, please explain:

At what age did the child: Respond to sound: _____ Follow an object: _____ Hold their head up: _____ Vocalize: _____ Teethe: _____
Sit alone: _____ Crawl: _____ Walk: _____ Begin cow's milk: _____ Begin solid foods: _____

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

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

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

Have you chosen to vaccinate your child? ◯ No ◯ Yes, on a delayed or selective schedule ◯ Yes, on schedule
- If yes, please list any vaccination reactions:

Has your child received any antibiotics? ◯ Yes ◯ No
- If yes, how many times and list reason:

Night terrors or difficulty sleeping? ◯ Yes ◯ No If yes, please explain:

Behavioral, social or emotional issues? ◯ Yes ◯ No If yes, please explain:

How many hours per day does your child typically spend watching a TV, computer, tablet or phone?

How would you describe your child's diet? ◯ Mostly whole, organic foods ◯ Pretty average ◯ High amount of processed foods

ACKNOWLEDGEMENT & CONSENT

I confirm that I have read and understood the Clinic's privacy notice and I agree to the processing of my personal information, including information about my health, for the purposes described in the notice.

Signature: _____ Date: _____

Patient Signature: _____ Date: __/__/____

Chiro Family Practice,
2A Cleveland Avenue, DerbybDE21 6SA

Privacy Notice

(About the information the Clinic holds on you)

What we need

Chiro Family Practice and Massage Therapy Derby is what is known as the 'Controller' of the personal information you provide to the Clinic. We collect personal data about you including contact details, information about your health and medical history, as well as your lifestyle. We keep records of your appointments and add information about your treatment to your individual file.

Why we need it

We need to know your contact details in order to contact you about appointments, to let you know of anything we are legally bound to send you and to provide you with information about your treatment and rehabilitation. We ask you for information about your health, medical history and lifestyle in order to diagnose your problem(s) and devise a treatment plan that is individual to you and your needs. We keep records of your treatment to check the effectiveness of your care and to keep your plan of care under review.

What we do with it

All the personal data we hold about you is kept on the Clinic's computer systems in the UK or using services that we have assessed as providing a high standard of security. No-one else has access to your personal data unless the law allows them to do so. If we need to inform other health professionals about your condition and treatment, such as your GP, we will only do so with your permission.

Chiro Family Practice and Massage Therapy Derby will not send you any marketing emails and will not sell or share your contact details with any other organisations.

We have reviewed the security of our systems and our data protection practices to ensure that we are operating within the requirements of the General Data Protection Regulation.

How long we keep it

We are required by the General Chiropractic Council (GCC) to keep records of treatment for 8 years. So we will keep your individual file for eight years after your last treatment with us. In the case of children, we are required to keep their records until they are twenty five years old.

Please note that we don't keep information about the credit or debit cards you use to make payments, as these are held only by the payment service we use.

What are your rights?

If at any point you believe the information we have about you is incorrect you can request to see this information and have it corrected. You have a right to ask for information to be deleted, but as the Clinic is required under GCC regulations to keep information about the treatment we have provided, we might not be able to do this. If you wish to raise a complaint on how we have handled your personal data, please contact the Clinic in the first instance.

If you are not satisfied with our response or believe we are processing your personal data not in accordance with the law you can complain to the Information Commissioner's Office (ICO). See ww.ico.org.uk/concerns

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