Patient Name: _____ Date: _____

Pediatric Questionnaire

Date of Birth: _____

Please answer the following questions:

1. Are you willing to follow a treatment program designed to help your child return to health for at least three months? (Treating the root causes)
   A. Yes B. No

2. Are you willing to have your child take nutritional supplements, if needed, for their particular case?
   A. Yes B. No

3. Are you willing to make dietary changes for your child, if needed, for their particular case?
   A. Yes B. No

4. Please rate on scale how serious you are about keeping your child healthy after their initial intensive care.

0	1	2	3	4	5	6	7	8	9	10
Not Serious										Very Serious

6. Please check the following that you are familiar with:

- ☐ Chiropractic
- ☐ Applied Kinesiology / Muscle Response Testing
- ☐ Holistic Healthcare / Functional Medicine

7. Concerning Chiropractic care, what have you experienced or heard, whether good or bad?

_____

_____

_____

<u>TREATMENT</u>: What type of treatment are you looking for?

- ☐ I am looking for the most minimal amount of care to "patch up the symptoms" of my child's problem.
- ☐ I am looking to resolve their symptoms and then go on to "fix the cause" of their problem so that it doesn't return.
- ☐ I am looking to take care of the cause of their problem and then go on to "achieve optimal health and wellness."

I understand that adjustments on a periodic maintenance basis can help prevent future issues and help maximize my child's health.

Please Note The Following Treatments That You Are Interested In At This Time:

- ☐ Chiropractic Care
- ☐ Applied Kinesiology/Muscle Response Testing
- ☐ Saliva Hormone Testing
- ☐ Functional Medicine Blood Work and Lab Testing
- ☐ Massage Therapy
- ☐ Neuro-Emotional Technique (Stress Reduction)
- ☐ Diet/Nutrition and Lifestyle Coaching
- ☐ Physical Therapy/Rehab
- ☐ Hair Analysis Heavy Metal Testing
- ☐ Detoxification/ Fasting/Cleansing
- ☐ Sports Medicine/Sports Performance
- ☐ Customized Nutritional Supplement Program
- ☐ Allergy Testing/Treatments
- ☐ Please evaluate and recommend what they need

Patient Name: _____ Date: _____

Office Use Only:
☐Entered into A8
☐Scanned

Child's Name:_____ DOB: _____ Age: _____

Mother's Name:_____ Cell Phone: _____

Father's Name:_____ Cell Phone: _____

Address: _____ City/ Town:_____ State: ____ Zip: _____

Email Address: _____ Alternate Phone: _____

Who can we thank for referring you? _____

Payment for Services will be by: ☐ Cash/Check/Credit Card ☐Health Insurance ☐Auto Ins. ☐ Work Comp

Insurance Co.: _____ ID #: _____

Insured's Name: _____ Insured's Date of Birth: _____

Are you the primary policy holder? ☐Yes ☐No If not- who is: _____

Insured's Address: _____City: _____State:_____ Zip: _____

Insured's Employer: _____Employer's Phone #: _____

Are you covered by more than one insurance company? ☐Yes ☐No

Name: _____

HEALTH CONCERNS/GOALS: Please list your top health concerns/goals in order of priority

1) _____

2) _____

3) _____

Have you been given a named diagnosis for your child's condition?_____

Type of Birth: ☐ Normal Vaginal ☐ Forceps: ☐ Cesarean: ☐ Suction Cup/Vacuum

Location: ☐ Home ☐ Birthing Center ☐ Hospital With: ☐ Doctor ☐ Midwife

During pregnancy did mom: ☐ Smoke ☐ Take medications ☐ Become ill ☐ Receive ultrasounds #__ ☐ Fall during pregnancy

Problems During Pregnancy: _____

Problems During Labor/Delivery: _____

Any evidence of trauma during birth? ☐ Bruises ☐ Odd shaped head ☐ Stuck in birth canal

Infant Feeding: Breast: ☐ Bottle: ☐ If Bottle, Which Formula:_____

Where does your child sleep? ☐ Parent's room ☐ Child's own room Any Problems? ☐ Yes ☐ No ☐ On Stomach ☐ On Back

Number of Hours Sleeping Per Night:_____ Quality of Sleep: ☐ Good ☐Fair ☐Poor

Obstetrician/Midwife:_____

Pediatrician/Family MD:_____

Date of Last Visit:___ ___ ___ Purpose: _____

Patient Name: _____ Date: _____

Immunization History: _____

Number of Doses Your Child Has Taken: During The Last Six Months:_____ During Lifetime:_____

Previous Chiropractor: _____

Date of Last Visit:____ ____ ____ Purpose:_____

Has your child ever been treated by: □D.C. □ M.D. □Acupuncturist □ Other_____

Has Your Child Ever Been Treated on an Emergency Basis? □ Yes □ No

If Yes, Please Explain:_____

_____

HAS YOUR CHILD EVER SUFFERED FROM:

- □ Dizziness
- □ Fainting
- □ Seizures/ Convulsions
- □ Colds/ Flu
- □ Colic
- □ Digestive Disorders
- □ Arm Problems
- □ Reflux
- □ Joint Problems
- □ Backaches
- □ Poor Posture
- □ Walking Trouble
- □ Broken Bones
- □ Neck Problems
- □ Stomach Aches
- □ Skin Problems
- □ Constipation
- □ Diarrhea
- □ Chronic Earaches
- □ Scoliosis
- □ Orthopedic Problems
- □ Poor Appetite
- □ Leg Problems
- □ Behavior Problems

At what age, if ever, did your child suffer from the following childhood diseases?

Chicken Pox:_____ Mumps: _____ Measles: _____ Rubella:_____

German Measles:_____ Whooping Cough: _____ Other:_____

MEDICAL / FAMILY HISTORY: C= Child M = Mother F = Father

(Please indicate which conditions have been experienced by the above by marking appropriate boxes).

C	M	F		C	M	F		C	M	F	
□	□	□	AIDS	□	□	□	Epilepsy				
□	□	□	Anemia	□	□	□	German measles	□	□	□	Neck pain
□	□	□	Arthritis	□	□	□	Headaches	□	□	□	Nervousness
□	□	□	Asthma	□	□	□	Heart trouble	□	□	□	Numbness
□	□	□	Back pain	□	□	□	Hepatitis	□	□	□	Polio
□	□	□	Bladder trouble	□	□	□	High blood pressure	□	□	□	Poor circulation
□	□	□	Bone fracture	□	□	□	HIV/ARC	□	□	□	Rheumatic fever
□	□	□	Bowel control loss	□	□	□	Indigestion	□	□	□	Rheumatism
□	□	□	Cancer	□	□	□	Kidney disorder	□	□	□	Serious injury
□	□	□	Chest pain	□	□	□	Reproductive disorders	□	□	□	Sinus trouble
□	□	□	Concussion	□	□	□	Multiple sclerosis	□	□	□	Stroke
□	□	□	Convulsions	□	□	□	Muscular dystrophy	□	□	□	Thyroid disease
□	□	□	Diabetes					□	□	□	Tuberculosis
□	□	□	Dislocated joints								

SCARS / SURGICAL PROCEDURES: Has your child had any surgical procedures? □Yes □No List along with any scars:

Spine: □Cervical □Thoracic □Lumbar **Extremities:** □Shoulder / Elbow / Hand / Wrist □R □L

□Hip / Knee / Ankle / Foot □R □L

Abdominal / Chest: □Appendix □Colon □Gall Bladder □Heart □Lungs □Breast □Other: _____

Patient Name: _____ Date: _____

ALLERGIES/ SENSITIVITIES: Please check and list all allergies

□ Food: □Dairy □Wheat □Corn □Soy □Seafood □Gluten □Peanuts □Fruits □Other: _____
□ Medications: □Penicillin □Sulfa Drugs □Iodine □Insulin □Antibiotics □Other: _____
□ Seasonal: □Pollen □Dust □Hay □Mold □Chemical(s) □Smoke □Animals □Insects
□ Other: _____

Any Pets At Home? □ Yes □ No **Any Smokers At Home?** □ Yes □ No

PAST MEDICAL INJURIES: List all major injuries, accidents, fractures, hospitalizations, falls, _____

_____

Date of Last Lab / Blood Work: _____ Anything abnormal? _____

Date of most recent X-ray/MRI: _____ Anything abnormal? _____

Does your child have any noticeable digestive or bladder issues? □ Yes □ No

Number of bowel movements per day _____

Have they had any major dental work yet? _____

_____

Is there anything else you are concerned about or you feel the Doctor should know?

_____

_____

Patient's Parent/ Guardian Signature: _____ **Date:** _____

(By signing this I consent to treatment to my child)

Patient Name: _____ Date: _____

Patient Health Information Consent Form

We want you to know how your Patient Health Information (**PHI**) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (**PHI**) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is obligated to agree to those restrictions only to the extent they coincide with state and federal law.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. Our office may contact you periodically regarding appointments, treatments, products, services, or charitable work performed by our office. You may choose to opt-out of any marketing or fundraising communications at any time.
6. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
7. Patients have the right to file a formal complaint with our privacy official and the Secretary of HHS about any possible violations of these policies and procedures without retaliation by this office.
8. Our office reserves the right to make changes to this notice and to make the new notice provisions effective for all protected health information that it maintains. You will be provided with a new notice at your next visit following any change.
9. This notice is effective on the date stated below.
10. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

_____ _____

Signature of Patient's Guardian Date

For further information regarding this notice, please contact our office at 215-944-8424

Patient Name: _____ Date: _____

SIH Consent Form

At Samsel Integrative Health, LLC a licensed Chiropractor treats patients through manipulation of the spine, pelvis, extremities, and organs; and other supporting therapies as indicated. These "other supporting therapies" include but are not limited to:

- Percussion and massage therapy
- Cold laser therapy and kinesiotaping
- Diet, nutrition, and lifestyle coaching
- Pharmaceutical-grade nutritional, herbal, and homeopathic supplements
- Applied Kinesiology (AK) and Acupressure
- Rehab, electrical stimulation, ice, and traction therapies
- NET (Neuro-Emotional Technique) and other stress reduction techniques

Every treatment listed above is non-invasive; we do not inject any substances through the skin, prescribe or make recommendations or changes to any medications under any circumstances. Many of these therapies are not covered by insurance. All of the treatments listed above are used as an adjunct to the Chiropractic adjustment. They are designed to support the Chiropractic subluxation from reoccurring and help address the root causes of pain and dysfunction.

We use some additional methods to help us assess what will best help you with your treatment and lifestyle recommendations called muscle response testing or Applied Kinesiology (AK). These are always used in conjunction with all other appropriate testing such as detailed personal and family history; nutrition and lifestyle questionnaires; orthopedic, neurological, and chiropractic examinations; X-rays and MRI's, and other forms of diagnostic and laboratory testing. We never diagnose or assess any conditions or make any specific recommendations for your case, including nutritional supplements, based on AK or muscle response testing alone.

If you are currently under the care of a physician—please remain under that care. You should always consult with your family doctor or pediatrician considering any alternative treatments. If you are currently taking prescribed medication—please continue to take the medication unless your physician tells you to stop or wean off of them with their supervision. You must remain under the care of a family physician or a pediatrician while being treating at SIH. We cannot and do not act as your primary care physician or pediatrician under any circumstances.

If you receive Neuro-Emotional Technique (NET) or <u>any</u> other stress reduction technique it does not take the place of psychotherapy, counseling, or any psychiatric medications. This is not a substitution for any kind of therapy. If you are already receiving those therapies you must continue with those doctors or therapists until they release you. If you have any doubts as to whether you should be seeing someone please consult a licensed professional in those fields. If we think you should see someone, we will make that recommendation as well.

_____ Please initial that you read the first page and read the other side

Patient Name: _____ Date: _____

If we perform testing or treatment for allergies, we are testing for and treating sensitivities of the body, not true allergies as per blood or scratch tests or other traditional medical testing. If you have or suspect true allergies, especially severe ones, you should be and remain under the care of a medical allergist.

Please note that we do not diagnose, treat, or cure in any way infectious diseases, visceral or systemic diseases, pathology, or cancer. If you have or suspect you have any of the aforementioned, you must remain under the care of a medical physician for their primary diagnosis and treatment.

If we order blood tests or other lab tests like hair, saliva hormone, or stool tests, they are used as an adjunct to help guide us in your treatment, nutrition, and lifestyle recommendations. We do not perform any of them to diagnose disease or pathology. If disease or pathology is found, you should always consult your primary doctor or the appropriate medical physician.

Please read the following statement and sign if you agree:

I understand that Chiropractic care is not a substitute for the care of my physician or medical specialist; and I understand that I am not to reduce, change or stop any medications I am currently taking unless my physician tells me to. I have read and agree with all that is contained in this document. I consent to be treated with Chiropractic and any of the therapies listed above based on the doctor's assessment. I intend this consent to apply to all of my past, present, and future treatments at this clinic.

If you have questions about anything on this form, please ask us before signing or receiving any treatment.

_____ *Date:* _____

Patient signature (or parent/guardian of minor)