IDEAL CHIROPRACTIC HEALTH CENTER

WELCOME

CHILD'S INITIAL QUESTIONNAIRE

Child Name: _____Preferred Name: _____

Birthdate: _____/ _____ /_____Age: _____ □ Male □ Female Weight: _____lbs. Height: _____Ft. _____In.

Mailing Address: _____City: _____State: _____Zip:_____

Daytime Phone:_____Evening Phone: _____

Status: □ Minor Brothers/Sisters: □ Yes □ No How many: _____

Parent's Names: _____Email: _____

Referred By: _____

ACCOUNT INFORMATION (Person Ultimately Responsible For Account Parent or Legal Guardian)

Name: _____Relation: _____Work Phone: _____

Billing Address:_____City:_____State: _____Zip:_____

Payment Method: □ Cash □ Check □ Credit Card

Credit Card Number: _____ Exp. Date: _____ Initial Here: _____

I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office.)

INSURANCE INFORMATION **Please inform front desk of second insurance source.*

Company Name: _____Phone #:_____

Insured's Id #: _____ Group # (Plan, Local, Policy #): _____

Insured's Name: _____ Relation: _____

REASON FOR VISIT

What is your primary pain/complaint? _____

_____

Describe the quality of your primary pain/compliant, is it (circle any that apply): sharp, dull, crushing, burning, tearing, or tingling?

*Is there any pattern to the quality of your pain, such as (circle all that apply): intermittent, constant, or throbbing?

*On a scale of 0-10, with 10 being the greatest pain, what is your pain rating when you are suffering (circle a number):0 1 2 3 4 5 6 7 8 9 10?

What date did you first notice your primary pain/complaint? _____

_____

Did something cause your primary pain/complaint to begin? _____

_____

If you saw any doctor or health care practitioner for your primary pain/compliant, please list their names and what they did, or prescribed, for you:

Doctor/Health Practitioner's Name:	What they did, or prescribed, for you:

HEALTH HISTORY

Please list any other serious medical conditions your child has or ever had: _____
_____
Does your child have any current health conditions or health challenges? _____
_____
Allergies: _____

Previous surgeries/treatments with dates: _____

Any past serious accident with dates: _____

Family health history: _____

Does your child take supplements/vitamins? □ Yes □ No Exercise? □ Yes □ No

Is your child on a special diet? □ Yes □ No Since: ___/___/_____

Does your child wear: □ Heel lifts □ Sole lifts □ Inner soles □ Arch supports

What is the age of your child's mattress? _____ Is it comfortable? □ Yes □ No

CONSENT TO CHIROPRACTIC CARE OF A MINOR CHILD

- We invite you to discuss with us any questions regarding our services. The best health services are based on friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider and or managed care organization, to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.
- I hereby authorize Drs. Ryan and Katie Effertz D.C. and whomever he may designate as his assistants to examine and administer chiropractic care as he so deems necessary to my son/daughter,
  (Child's name) _____

Parent/Guardian Signature: _____ Date: _____

2200 John F Kennedy Rd., Dubuque, IA
563|845|7283
Healthydubuque.com