2251 Double Creek Dr, Suite #401, Round Rock, TX 78664
512-246-0220

Child & Adolescent Initial Questionnaire

Appt. Date: _____ Referred By: _____
Name (first, middle, last) _____ Preferred Name: _____
Address_____ City _____ State ____ Zip_____
Home Phone (____) _____ Mom Cell (_____) _____ Dad Cell (_____) _____
Social Security # _____ Date of Birth___/___/___ Age____ □Male □Female
Mother's Name _____Father's Name _____
Email Address: _____

1. **Tell us about your pregnancy;**
   Did you carry to full term? □ Yes □ No If not, how long? _____
   Describe any complications and when they occurred: _____
   _____

2. **Tell us about your delivery and birth of this child:**
   Did you use a midwife? □ Yes □ No
   Did you go to a hospital? □ Yes □ No
   Did you use an obstetrician? □ Yes □ No
   Did you have a C-Section? □ Yes □ No
   Was it a difficult birth? □ Yes □ No
   Were forceps used? □ Yes □ No
   Vacuum Extraction? □ Yes □ No
   Were you induced? □ Yes □ No
   Did you have an Epidural? □ Yes □ No
   How much did the baby weigh? _____

   What was the baby's **APGAR** Score? _____ At 5 minutes? _____

3. **Tell us more:**
   Did you breastfeed? □ Yes □ No How long? _____ What formula after? _____
   Did you consume alcohol during your pregnancy? □ Yes □ No If so, how much? _____
   Did you smoke? □ Yes □ No If so, how much?_____How long? _____
   Did you take any medication during your pregnancy? □ Yes □ No
   What type and for what? _____
   _____
   Any exposures to ultrasound? □ Yes □ No How many?_____

4. **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
   ___ Did not gain weight
   ___ Frequent crying spells
   ___ Frequent fevers
   ___ Frequent bouts of diarrhea
   ___ Constipation
   ___ Sleeping problems
   ___ Reaction to vaccination
   ___ Play in a Jolly Jumper
   ___ Frequent colds
   ___ Frequent ear infections
   ___ Colic
   ___ Tonsillitis
   ___ Other: _____

   Please explain the above: _____

5. **As a young child, (5-12 years), did any of the following occur?**
   ___ Fall from a tree
   ___ Sports accident
   ___ Hyperactivity/Autism
   ___ Asthma
   ___ Scoliosis
   ___ Fall of a bicycle
   ___ Car accident
   ___ Learning difficulties
   ___ Allergies
   ___ Other: _____
   ___ Fall of playground equipment
   ___ Bed wetting
   ___ Stomach pains
   ___ Leg/knee pains

   Please explain the above: _____

6. List any vaccinations your child has had:_____
_____
_____
_____

Any reactions to these? □ Yes □ No If so, what reaction? Please describe: _____
_____
_____

7. As a child or adolescent, has your child experienced any of the following:

___ Headaches	___ Numbness in arms/hands	___ Foot/ankle/knee pains
___ Dizziness	___ Arm/wrist pain	___ Tingling in arms/legs
___ Ringing in ears	___ Sleeping problems	___ Neck/back pains
___ Asthma	___ Allergies	___ Shoulder pains
___ Hyperactivity	___ Stomach problems	___ Growing Pains
___ Fatigue	___ Weight gain/loss	___ Other _____

Please explain any of the above: _____
_____

8. Which of the problems you have checked off is the worst? _____

Is this problem: (circle one): 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? _____

9. What effect does this problem have on your child's body functions? _____
_____

Does it have any effect on his/her participation in daily activities? □ Yes □ No If yes, please explain: _____
_____

10. Describe any hospital stays: _____

11. Approximately how many times have antibiotics been prescribed and for what conditions?
_____

12. List any medications your child is currently taking: _____
_____

13. To summarize, what is your purpose for this appointment? _____
_____

14. Is there anything else you feel we should know? _____
_____
_____

Name of Parent or Guardian: _____ Date: _____

Signature of Parent or Guardian: _____

FAMILY HEALTH HISTORY

Please review the diseases and conditions listed below and indicate those that are current health problems of a family member by the designation "C" under his/her column, and those that are past health problems by the designation of "P" under his/her column. Leave blank those spaces which do not apply.

	Father	Mother	Siblings			
Condition:	**Age: _____**	**Age: _____**	**Age: ____**	**Age: ____**	**Age: ____**	**Age: ____**
ADHD						
Allergies						
Arthritis						
Asthma						
Autism						
Back Trouble						
Bed Wetting						
Bursitis						
Cancer						
Chest Pain						
Colic						
Constipation						
Crohns Disease						
Depression						
Diabetes						
Diarrhea						
Disc Problems						
Down Syndrome						
Ear Infection						
Emotion Issues						
Emphysema						
Epilepsy						
Headaches						
Migraines						
Heartburn						
Heart Trouble						
High Blood Press						
IBS						
Indigestion						
Infertility						
Insomnia						
Kidney Trouble						
Neck Pain						
Neuritis						
Nervousness						
Pinched Nerve						
Scoliosis						
Sinus Trouble						
Acid Reflux						
Other: _____						

RELEASE AND CONSENTS

AUTHORIZATION TO TREAT A MINOR CHILD

I authorize Dr. Blair Miller, D.C. and/or Dr. Marie Pappas, D.C., licensed Doctors of Chiropractic in the state of Texas, to administer diagnoses and treatment as deemed necessary to my son/daughter/other: _____
I also authorize the provider(s) to release any information required to process insurance claims.

Child's Name: _____

Signature of Guardian: _____

Relationship to Patient: _____

Date: _____

CONSENT TO X-RAY EXAMINATIONS
If and when deemed necessary, I do hereby consent to X-ray examination to be performed by an outside facility.

Females: I will notify the doctors if I believe that I could be pregnant so that the proper precautions will be taken.

Last Menstrual Period Date _____

Signature of Responsible Person: _____ Date: _____

HIPAA

Consents Name of Practice: Holistic Chiropractic and Wellness PLLC
Address: 2251 Double Creek Dr, Suite #401
Round Rock, TX 78664
Privacy Contact: Dr. Blair Miller, D.C.
Telephone: 512-246-0220

** I understand that I do not have to sign this authorization in order to receive treatment from this practice, but when my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule.

NOTICE OF PRIVACY PRACTICE RECEIPT:
I acknowledge that I was provided with the Notice of Privacy Practices of the Chiropractic Practice named at the top of this page.

Printed Name of Patient: _____
Signature of Patient: _____
Date: _____
Patient's Date of Birth: _____

For Personal Representative of the Patient (only if applicable)

Print Name of Personal Representative: X_____
Relationship (parent, guardian, etc.): X_____
Signature of Personal Representative: X_____
Reason Patient unable to sign: _____

_____ _____
Practice Employee Date

ALL PATIENTS PLEASE PROVIDE THE FOLLOWING

May we release appointment, billing and medical information to anyone other than you? ___YES ___NO

Name(s) of the person(s) we may release your information to: _____

* I hereby authorize Holistic Chiropractic and Wellness PLLC to release periodic status reports from the medical records of the patient listed below. The reports may be released to other physicians or facilities participating in my care.
* I understand my records are confidential and cannot be disclosed without my written authorization, except otherwise provided by law.
* I understand that records pertaining to the diagnosis and/or treatment of HIV/AIDS testing, psychiatric illness and alcohol or chemical abuse dependency will not be released unless I have given my specific consent to release this information.
* I understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance upon it and that this authorization will automatically expire on one year from date signed.
* I understand that a photocopy or facsimile of this authorization is as valid as the original.
* I authorize the release of any medical billing or other information necessary to process claims on my behalf.
* I agree to be fully responsible for all lawful debts incurred by myself (or dependents under care) for services received from Holistic Chiropractic and Wellness PLLC
* I understand that any verbal consent or intent to use photographs or social media network sharing by the patient or provider is protected as valid written consent when patient, other patient, or provider agreed on photographed educational testimonies.

_____
Signature of Patient

_____ _____
Printed Name Date

Please initial one box below:
If our office attempts to contact you and a message is taken by an answering machine/voicemail or another person, it is appropriate to leave a:
____ Detailed message regarding condition, appointments, or payments.
____ Message to call Round Rock Health & Wellness Center

NOTICE OF PRIVACY PRACTICES

Effective April 14, 2003
Revised According to New HIPAA Regulations September 23, 2013
Holistic Chiropractic and Wellness PLLC is committed to protecting your protected health information.
"Protected Health Information" (PHI) may include such items as: medical notes from your doctor, a claim from your provider listing your diagnosis, a medical treatment that you received, or laboratory/diagnostic test results. This notice about protecting your PHI is required by law. It tells you about your rights and how we use and disclose your health information.

YOUR HEALTH INFORMATION RIGHTS

- Request a restriction on certain uses and disclosures of your PHI; however, we are not required to approve your request.
- Request that we notify you about your PHI in a way or at a location that will help you keep your information confidential.
- Receive a list of certain disclosures we have made of your PHI. This is a list of disclosures made by us during a specified period of up to six years *except for disclosures made:*
    - For treatment, payment, and healthcare operations
    - For use in or related to a facility directory
    - To family members or friends involved in your care
    - To you directly
    - Pursuant to an authorization of you and your personal representative
    - For certain notification purposes (including national security, intelligence, correctional, and law enforcement purposes)
    - Before April 14, 2003
- In writing at any time, withdraw your permission for us to disclose your PHI, except for the information that we disclose before you stopped your permission.
- Review and obtain a copy of your own PHI.
- Ask us to change your PHI if you believe it is incorrect or incomplete. We may deny your request and, if so, will give you the reason(s) why the request was denied.
- Receive a paper or electronic copy of this Notice of Privacy Practices upon request.

HOW Holistic Chiropractic and Wellness PLLC MAY USE OR DISCLOSE YOUR PHI: The examples included with each category do not list every type of use or disclosure that may fall within that category. FOR TREATMENT: We may use and disclose your PHI to a physician or other healthcare provider providing treatment to you.
PAYMENT: We may use and disclose your PHI to obtain payment for services we provided to you. HEALTHCARE OPERATIONS: We may use and disclose your PHI in connection with chiropractic operations, including quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner performance, conducting training programs, accreditation, certification, licensing, or credentialing activities.
REQUIREMENTS BY LAW: We may use and disclose your PHI when required to do so by law. We may also use or disclose your PHI to public health authorities or other authorized persons to carry out certain activities related to public health, including the following:

- To prevent or control disease, injury or disability.
- To report disease, injury, birth or death.
- To report child abuse or neglect.
- To report reactions to medications or problems with products or devices regulated by the federal Food and Drug Administration or other activities related to quality, safety, or effectiveness of FDA regulated products or activities.
- To locate and notify persons of recalls of products they may be using.
- To notify a person who may have been exposed to a communicable disease in order to control who may be at risk of contracting or spreading the disease.
- To report to your employer, under limited circumstances, information related primarily to workplace injuries or illness, or workplace medical surveillance.

We may also use and disclose your PHI under certain circumstances for the following purposes where the disclosure is:

- About a suspected crime victim if, under certain limited circumstances, we are unable to obtain a person's agreement because of incapacity or emergency.
- To alert law enforcement of a death that we suspect was the result of criminal conduct.
- In response to a court order, warrant, subpoena, summons, administrative agency request, or other authorized process.
- To identify or locate a suspect, fugitive, material witness, or missing person.
- About a crime or suspected crime committed at the workplace.
- In response to a medical emergency not occurring at the workplace, if necessary to report a crime, including the nature of the crime, the locations of the crime or the victim, and the identity of the person who committed the crime.

HEALTH OVERSIGHT ACTIVITIES: We may disclose your PHI to government health agencies for health oversight reasons, such as program audits or licensure reviews.
RESEARCH: We may use your PHI for approved research purposes, such as for study to cure a disease. SPECIAL GOVERNMENT FUNCTIONS: We may, such as protection of public officials or reporting to various branches of the armed services, require the use or disclosure of your PHI.
OTHER USES: We may use and disclose your PHI to your family member, close friend, or any other person identified by you if that information is directly relevant to the person's involvement in your care or payment for your care.

OBLIGATIONS OF Holistic Chiropractic and Wellness PLLC

- Maintain the privacy of your PHI.
- Provide you with the Notice of its legal duties and privacy practices with respect to your PHI.
- Obtain your written authorization to use or disclose your PHI for reasons other than those listed in this Notice and permitted by law.
- Abide by the terms of this Notice that are currently in effect.
- Notify you if we are unable to agree to requested restriction on how your PHI is used or disclosed.
- Allow reasonable requests you may make to notify you about your PHI in a way or at a location that will help you keep your PHI confidential.

Holistic Chiropractic and Wellness PLLC reserves the right to change its information practices. The new provisions will be effective for all PHI that Holistic Chiropractic and Wellness PLLC maintains. Revised notices will be made available to you by written notices.

COMPLAINTS:
If you have a complaint about how Holistic Chiropractic and Wellness PLLC handles your PHI, or if you otherwise believe that your privacy rights have been violated by Holistic Chiropractic and Wellness PLLC , your complaint should be directed to:
Holistic Chiropractic and Wellness PLLC , 2251 Double Creek Dr, Suite #401 Round Rock, TX 78664 (512) 246-0220
Attention: Privacy Contact
If you are not satisfied with the manner in which Holistic Chiropractic and Wellness PLLC handles a complaint, you may submit a formal complaint to the U.S. Secretary of Health and Human Services in Washington, D.C. There will be no retaliation by Holistic Chiropractic and Wellness PLLC if you file a complaint.