

# Pediatric Patient Questionnaire

Child's Name \_\_\_\_\_ Perent(s)/Guardian(s)name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Is it ok to contact you at work?  Yes  No

Email: \_\_\_\_\_ Birthdate \_\_\_\_\_ Age \_\_\_\_\_

Have you or your child ever had chiropractic care before?  Yes  No

If yes, please tell us the doctor name \_\_\_\_\_

Were you pleased with your care?  Yes  No

How did you hear about our office? \_\_\_\_\_

Is this appointment related to an auto accident?  Yes  No

Is your child receiving care from other health professionals?  Yes  No

If so, please name them and their specialty \_\_\_\_\_

Who is your family's primary care physician? \_\_\_\_\_

Please list any drugs or medications your child is taking \_\_\_\_\_

\_\_\_\_\_

Please list any vitamins/herbs/homeopathies/other your child is taking \_\_\_\_\_

\_\_\_\_\_

Please list any allergies your child has \_\_\_\_\_

\_\_\_\_\_

What health condition brings your child to our office? \_\_\_\_\_

\_\_\_\_\_

When did the symptoms first begin? \_\_\_\_\_

How did the problem start?  Suddenly  Gradually  Post-injury

Is this condition  Getting Worse  Improving  Intermittent  Constant  Not sure

What makes the problem better? \_\_\_\_\_

What makes the problem worse? \_\_\_\_\_

Has your child ever had a similar condition?  Yes  No

Please explain \_\_\_\_\_

Has your child been treated for this problem before?  Yes  No

Please explain \_\_\_\_\_

Does your child eat well?  Yes  No

Does your child have regular bowel/bladder movements?  Yes  No

Has your child ever been checked for vertebral subluxations?  Yes  No  Don't Know

Child's birth was \_\_\_ At home \_\_\_ At a birthing center \_\_\_ At a hospital

My obstetrician/midwife/family physician was \_\_\_\_\_

Child's birth was \_\_\_ Natural vaginal (no medications/interventions)

\_\_\_ Vaginal with interventions

\_\_\_ Induction \_\_\_ Pain medication \_\_\_ Epidural \_\_\_ Episiotomy

\_\_\_ Vacuum extraction \_\_\_ Forceps

\_\_\_ C-Section

\_\_\_ Scheduled \_\_\_ Emergency

Please list reasons for any interventions/complications \_\_\_\_\_

Child's birth weight \_\_\_\_\_ Child's birth height \_\_\_\_\_ Current weight \_\_\_\_\_ Current height \_\_\_\_\_

APGAR score at birth \_\_\_\_\_ APGAR score after 5 minutes \_\_\_\_\_

Was your child alert and responsive within 12 hours of delivery? \_\_\_ Yes \_\_\_ No

If no, please explain \_\_\_\_\_

At what age did the child

Respond to sound \_\_\_\_\_ Follow an object \_\_\_\_\_ Hold head up \_\_\_\_\_ Vocalize \_\_\_\_\_

Sit alone \_\_\_\_\_ Teethe \_\_\_\_\_ Crawl \_\_\_\_\_ Walk \_\_\_\_\_

Patient/Hospitalization/Surgical history (please list below all surgeries and hospitalizations, including this year)

Is/was your child breastfed? \_\_\_ Yes \_\_\_ No If so, how long? \_\_\_\_\_

Formula introduced at age \_\_\_\_\_ What type? \_\_\_\_\_

Introduction of cow's milk at age \_\_\_\_\_ Began solid foods at age \_\_\_\_\_

Please list any foods/juice intolerance \_\_\_\_\_

Did mother smoke during pregnancy? \_\_\_ Yes \_\_\_ No

Did mother drink alcohol during pregnancy? \_\_\_ Yes \_\_\_ No

Any illness of mother during pregnancy? \_\_\_ Yes \_\_\_ No

If yes, please explain including treatment/medications/supplements \_\_\_\_\_

List any drugs/medications (including over the counter) taken during pregnancy \_\_\_\_\_

List any supplements taken during pregnancy \_\_\_\_\_

Any exposures to ultrasound? \_\_\_ Yes \_\_\_ No If so, how many and what was the medical reason? \_\_\_\_\_

Any pets at home? \_\_\_ Yes \_\_\_ No Any smokers at home? \_\_\_ Yes \_\_\_ No

Has child received any vaccinations?  Yes  No

If yes, which ones and list any reactions \_\_\_\_\_

Has child received any antibiotics?  Yes  No If yes, how many times and list reason \_\_\_\_\_

Any difficulty with breastfeeding?  Yes  No If yes, please explain \_\_\_\_\_

Any difficulty with bonding?  Yes  No If yes, please explain \_\_\_\_\_

Any behavioral problems?  Yes  No If yes, please explain \_\_\_\_\_

Any night terrors, sleepwalking, or difficult sleeping?  Yes  No If yes, please explain \_\_\_\_\_

Age child began daycare \_\_\_\_\_ Average number of hours of TV per week \_\_\_\_\_

Does your child seem normal for their age?  Yes  No If no, please explain \_\_\_\_\_

### Family History

Asthma  Mom  Dad  Other Seizures  Mom  Dad  Other

Allergies  Mom  Dad  Other Headaches  Mom  Dad  Other

Anemia  Mom  Dad  Other Autism  Mom  Dad  Other

Blood disorder  Mom  Dad  Other Depression  Mom  Dad  Other

Cancer  Mom  Dad  Other Anxiety  Mom  Dad  Other

Diabetes  Mom  Dad  Other ADD/ADHD  Mom  Dad  Other

High cholesterol  Mom  Dad  Other Alcoholism  Mom  Dad  Other

High blood pressure  Mom  Dad  Other Thyroid disease  Mom  Dad  Other

Heart Attack/disease  Mom  Dad  Other Other \_\_\_\_\_

Do you know what a subluxation is?  Yes  No

Do any of your friends or relatives see a chiropractor?  Yes  No

If yes, do they use chiropractic for  Health maintenance/optimization  Health problems  Both

Are you seeking chiropractic for  Health maintenance/optimization  Health problems  Both

What would you like to gain from chiropractic care? \_\_\_\_\_

Are there other health concerns or anything else you'd like us to know about your child? \_\_\_\_\_

Parent(s)/Guardian Signature

Date

# Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an "arterial dissection" that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately a percentage of these patients will experience a stroke.

The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events/ per one million persons/year and risk of death has been estimated as 104 per one million users.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent or Guardian: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

RiverPath Chiropractic is required by law to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

## **DISCLOSURE OF YOUR HEALTH CARE INFORMATION**

### **Treatment**

We may disclose your healthcare information to other healthcare professionals within our practice for the purpose of treatment, payment, or healthcare operations.

### **Payment**

We may disclose your health information to your insurance provider for the purpose of payment or healthcare operations.

### **Workers Compensation**

We may disclose your health information to as necessary to comply with State Workers' Compensation Laws.

### **Emergencies**

We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or of your death.

### **Public Health**

As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury, or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reaction to medications, and reporting disease or infection exposure.

### **Judicial and Administrative Proceedings**

We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

### **Deceased Persons**

We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues.

**Research**

We may disclose your health information to researchers conducting research that has been approved by the Institutions Review Board.

**Public Safety**

It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to health or safety of a particular person or to the general public.

**Marketing**

We may contact you for marketing purposes of fundraising purposes.

**Specialized Government Agencies**

We may disclose your health information for military, national security, prisoner and government benefits purposes.

**Change of Ownership**

In the event that RiverPath Chiropractic is sold or merged with another organization, your health information/record will become the property of the new owner.

**Your Health Information Rights**

- You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that RiverPath Chiropractic is not required to agree to the restriction you requested.
- You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.
- You have the right to inspect and copy your health information.
- You have a right to request that RiverPath Chiropractic amend your protected health information. Please be advised, however, that RiverPath Chiropractic is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.
- You have a right to receive an accounting of disclosures of your protected health information made by RiverPath Chiropractic. you have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

**Changes to this Notice of Privacy Practices**

RiverPath Chiropractic reserves the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, RiverPath Chiropractic is required by laws to comply with this notice.

RiverPath Chiropractic is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights, please contact Drs. Kim and Chris McHugh (DCs), on their office phone at (858) 369-0114. If they are not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

**Complaints**

Complaints about your Privacy Rights or how RiverPath Chiropractic has handled your health information should be directed to Drs. Kim and Chris McHugh, by calling their office at (858) 369-0114. If they are not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights  
200 Independence Avenue, S.W.  
Room 509F, HHH Building  
Washington DC 20201

This notice is effective as of March 1, 2016.

I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide RiverPath Chiropractic with my authorization and consent to use and disclose my protected healthcare information for the use purposes of treatment, payment, and healthcare operations as described in the Privacy Notice.

\_\_\_\_\_  
Patient's Name (print)

\_\_\_\_\_  
Patient/Legal Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Authorized Facility Signature

\_\_\_\_\_  
Date

# License Notice

As of August 11, 2022, I, Christopher Michael McHugh, have chosen not to renew the chiropractic license with the STATE OF CALIFORNIA. There are pros and cons to this decision.

**Pros:** I am free to do what is best for you. I am able to learn, study, and grow based on what I know and feel to be the most important.

**Cons:** I am not able to take health or car insurance. I am unable to write super-bills.

**I will continue to accept the following:**

- Cash
- Gold/Silver
- Trades
- Credit/Debit/HSA/CareCredit

**I will continue to serve you and your family with my fullest love and attention.**

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Signature

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Date