



# Initial Child & Adolescent Questionnaire

p. 1 of 3

Child's name: \_\_\_\_\_  
Age: \_\_\_\_\_ Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Month Day Year

Mom's: \_\_\_\_\_  
Dad's: \_\_\_\_\_

## Mainly for Moms:

### 1. Tell us about your pregnancy:

Did you carry to full term? \_\_\_\_\_

Describe any complications and when they occurred: \_\_\_\_\_

\_\_\_\_\_

### 2. Tell us about the delivery and birth of this child:

Did you use a midwife? \_\_\_\_\_ Hospital? \_\_\_\_\_ Obstetrician? \_\_\_\_\_

Did you have a C-section? \_\_\_\_\_ Were forceps used? \_\_\_\_\_

Vacuum extraction? \_\_\_\_\_ Were you induced? \_\_\_\_\_

Did you have an epidural? \_\_\_\_\_ Was it a difficult birth? \_\_\_\_\_

What was the baby's APGAR score? \_\_\_\_\_ At 5 minutes? \_\_\_\_\_

### 3. Tell us more:

Did you breastfeed? \_\_\_\_\_ How long? \_\_\_\_\_ What formula after? \_\_\_\_\_

Did you drink alcohol during pregnancy? \_\_\_\_\_ How much? \_\_\_\_\_

Did you smoke? \_\_\_\_\_ How much? \_\_\_\_\_ How long? \_\_\_\_\_

Did you take any medication during pregnancy? \_\_\_\_\_ For what? \_\_\_\_\_

What type? \_\_\_\_\_

Did you have any exposures to ultrasound? \_\_\_\_\_ 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 a car accident

\_\_\_\_\_ Fall off playground equipment

\_\_\_\_\_ Play in a Jolly Jumper

\_\_\_\_\_ Frequent ear infections

\_\_\_\_\_ Tonsillitis

\_\_\_\_\_ Reaction to vaccination

\_\_\_\_\_ Frequent crying spells

\_\_\_\_\_ Frequent fevers

\_\_\_\_\_ Frequent bouts of diarrhea

\_\_\_\_\_ Constipation

\_\_\_\_\_ Sleeping problems

\_\_\_\_\_ Frequent colds

\_\_\_\_\_ Colic

\_\_\_\_\_ Did not gain weight

\_\_\_\_\_ Other \_\_\_\_\_

Please explain the above: \_\_\_\_\_

---

---

**5. As a young child, (5 to 12 years), did any of the following occur?**

- |  |  |
|--|--|
| <input type="checkbox"/> Fall from a tree              | <input type="checkbox"/> Bed wetting           |
| <input type="checkbox"/> Fall off a bicycle            | <input type="checkbox"/> Hyperactivity/Autism  |
| <input type="checkbox"/> Fall off playground equipment | <input type="checkbox"/> Learning difficulties |
| <input type="checkbox"/> Sports accident               | <input type="checkbox"/> Asthma                |
| <input type="checkbox"/> Car accident                  | <input type="checkbox"/> Allergies             |
| <input type="checkbox"/> Stomach pains                 | <input type="checkbox"/> Leg/knee pains        |
| <input type="checkbox"/> Scoliosis                     | <input type="checkbox"/> Other                 |

Please explain any of the above: \_\_\_\_\_

---

---

**6. Tell us about any vaccinations your child has had: \_\_\_\_\_**

---

---

Any reactions to any of these? \_\_\_\_\_

---

---

Were you told you had a choice in whether to vaccinate your child? \_\_\_\_\_ Yes \_\_\_\_\_ No

Would you like information about the other side of the issue? \_\_\_\_\_ Yes \_\_\_\_\_ No

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

- |   |   |
|---|---|
| <input type="checkbox"/> Headaches        | <input type="checkbox"/> Numbness in arms/hands |
| <input type="checkbox"/> Dizziness        | <input type="checkbox"/> Foot/knee/ankle pains  |
| <input type="checkbox"/> Ringing in ears  | <input type="checkbox"/> Arm/wrist pains        |
| <input type="checkbox"/> Asthma           | <input type="checkbox"/> Tingling in arms/legs  |
| <input type="checkbox"/> Allergies        | <input type="checkbox"/> Shoulder pains         |
| <input type="checkbox"/> Hyperactivity    | <input type="checkbox"/> Growing pains          |
| <input type="checkbox"/> Stomach problems | <input type="checkbox"/> Weight loss/gain       |
| <input type="checkbox"/> Fatigue          | <input type="checkbox"/> Other _____            |

Please explain any of the above: \_\_\_\_\_

---

---

8. Which of the problems you checked off was/is the worst? \_\_\_\_\_

Is this problem: \_\_\_\_\_ Constant; \_\_\_\_\_ Intermittent; \_\_\_\_\_ Occasional; \_\_\_\_\_ Cyclic

9. How long has it persisted? \_\_\_\_\_

10. When it is at its worst, how does it make your child feel? \_\_\_\_\_

11. What have you done about it that has NOT worked? \_\_\_\_\_

12. What makes it worse? \_\_\_\_\_

13. What effect does this problem have on your child's body functions? \_\_\_\_\_

On his/her participation in daily activities? \_\_\_\_\_

14. Describe any hospital stays: \_\_\_\_\_

15. Approximately how many times have antibiotics been prescribed for this child and for what conditions: \_\_\_\_\_

16. List any medications your child is taking currently: \_\_\_\_\_

17. To summarize, what is your purpose for this appointment? \_\_\_\_\_

18. Is there anything else you feel we should know? \_\_\_\_\_

Signature of parent/guardian: \_\_\_\_\_

Date: \_\_\_\_\_

Thank You!

## Consent to Treatment of a Minor

I HEREBY AUTHORIZE:

DR. \_\_\_\_\_

AND WHOMEVER HE MAY DESIGNATE AS ASSISTANTS TO ADMINISTER  
CHIROPRACTIC CARE AS DEEMED NECESSARY. I WILL BE FULLY  
RESPONSIBLE FOR PAYMENT OF ALL SERVICES RENDERED.

TO:

MY \_\_\_\_\_, \_\_\_\_\_  
(INDICATE RELATIONSHIP) (NAME OF MINOR)

DATE: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_  
PARENT OR LEGAL GUARDIAN

WITNESS: \_\_\_\_\_

## Consent for Radiology

DATE: \_\_\_\_\_

### **FOR SELF**

I, \_\_\_\_\_, give Dr. Todd Lebson of Lebson Chiropractic and Wellness Center, my consent to take any and all x-rays needed to better understand my condition. I have been fully informed of the possible risks and safety standards of this office.

Patient (Parent) Signature: \_\_\_\_\_

### **FOR LADIES ONLY**

To my best knowledge I am not pregnant and know of no contraindications for x-rays at this time.  
When was the first day of your last menstrual cycle? \_\_\_\_\_

Patient (Parent) Signature: \_\_\_\_\_

### **FOR CHILD**

I give my consent for films of my child, \_\_\_\_\_, for the same reasons stated above, if applicable.

Patient (Parent) Signature: \_\_\_\_\_

Thank You

## Our Fee Structure

**Please note our fees for your initial visit.  
Your insurance may cover these costs entirely, partially, or not at all.**

<i><b>Evaluation</b></i>	Complimentary
<i><b>Examination</b></i>	\$100.00
<i><b>Radiology</b></i>	\$50.00 (per set of 2)
<b>TOTAL</b>	<b>\$150.00 (minimum)</b>

Please note that if you have been involved in a motor vehicle accident, our fee structure may differ due to the complexity of your needs in such cases.

I fully understand the above fees and give my consent. I also give my consent to have the doctor take any x-rays he/she deems appropriate to better understand my problem and monitor my progress.

SIGNATURE: \_\_\_\_\_  
Signature of Parent/Guardian required if patient is under age 18

DATE: \_\_\_\_\_

Thank You!

**NORTH SHORE FAMILY CHIROPRACTIC, P.C.**  
400 South Oyster Bay Rd. Suite 205, Hicksville, N.Y. 11801, (516)-433-5396

---

**HIPAA Notice of Privacy Practices**

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

This Notice Of Privacy practices how we may use and disclose your protected health information (PHI) to carry out treatment. Payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that might identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

**Uses and Disclosures of Protected Health Information.** Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physicians practice, and any other use required by law.

**Treatment:** We will use and disclose protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

**Payment:** Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

**Healthcare Operations:** We may use or disclose, as needed, your protected health information in order to support the business activities of your physicians practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing and conduction or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

**We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and organ donation: Research: Criminal Activity: Military Activity and National Security: Workers Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Security of the Department of Health and Human Services to investigate or determine our compliance with the requirements of section 164.500. Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization or opportunity to object unless required by law.**

**PATIENT CONSENT FORM**

The Department of Health and Human Services has established a “privacy Rule” to help insure that personal health care information is protected for privacy. The privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients’ consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your healthcare information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you ( such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer.

You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice

Print Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

---

**COMPLIANCE ASSURANCE NOTIFICATION FOR OUR PATIENTS**

To Our Valued Patients:

The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation, and money. We want you to know that all of our employees, managers and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the “Privacy Rule”. We strive to achieve the very highest standards of ethics and integrity in performing services for our patients.

It is our policy to properly determine appropriate use of PHI in accordance with the governmental rules, laws and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI.

We also know that we are not perfect! Because of this fact, our policy is to listen to our employees and our patients without any thought of penalization if they feel that an event in any way compromises our policy of integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation promptly.

Thank you for being one of our highly valued patients.

**NORTH SHORE FAMILY CHIROPRACTIC, P.C.**  
400 South Oyster Bay Rd. Suite 205, Hicksville, N.Y. 11801, (516)-433-5396

---

You may revoke this authorization at any time, in writing, except to the extent that your physician or the physicians practice has taken an action in reliance on the use or disclosure indicated in the authorization.

**Your Rights.** Following is a statement of your rights with respect to your protected health information.

**You have the right to inspect and copy your protected health information.** Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

**You have the right to request a restriction of your protected health information.** This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations, you may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you might request. If physician believes it is in your best interest to permit use and disclosure of your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

**You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us,** upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

**You may have the right to have your physician amend your protected health information.** If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

**You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.**

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

**Complaints**

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

This notice was published and becomes effective on/or before April 14, 2003

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number

Signature below is only acknowledgement that you have read this policy.

Print Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_