



2251 Double Creek Dr, Suite #501, Round Rock, TX 78664
512-246-0220, ext. 2

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? <input type="checkbox"/> Yes <input type="checkbox"/> No	Were forceps used? <input type="checkbox"/> Yes <input type="checkbox"/> No
Did you go to a hospital? <input type="checkbox"/> Yes <input type="checkbox"/> No	Vacuum Extraction? <input type="checkbox"/> Yes <input type="checkbox"/> No
Did you use an obstetrician? <input type="checkbox"/> Yes <input type="checkbox"/> No	Were you induced? <input type="checkbox"/> Yes <input type="checkbox"/> No
Did you have a C-Section? <input type="checkbox"/> Yes <input type="checkbox"/> No	Did you have an Epidural? <input type="checkbox"/> Yes <input type="checkbox"/> No
Was it a difficult birth? <input type="checkbox"/> Yes <input type="checkbox"/> 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?

- | | | |
|--|---|--|
| <input type="checkbox"/> Fall from a change table | <input type="checkbox"/> Frequent crying spells | <input type="checkbox"/> Play in a Jolly Jumper |
| <input type="checkbox"/> Tumble down stairs | <input type="checkbox"/> Frequent fevers | <input type="checkbox"/> Frequent colds |
| <input type="checkbox"/> Fall out of crib | <input type="checkbox"/> Frequent bouts of diarrhea | <input type="checkbox"/> Frequent ear infections |
| <input type="checkbox"/> Involved in car accident | <input type="checkbox"/> Constipation | <input type="checkbox"/> Colic |
| <input type="checkbox"/> Fall off playground equipment | <input type="checkbox"/> Sleeping problems | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Did not gain weight | <input type="checkbox"/> Reaction to vaccination | <input type="checkbox"/> Other: _____ |

Please explain the above: _____

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

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

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:

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

Condition:	Father	Mother	Siblings			
	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 Spiller, Dr. Amanda Ming Ulloa, and/or Dr. Jen Dufala, 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, Inc.

Address: 2251 Double Creek Dr, Suite #501
Round Rock, TX 78664

Privacy Contact: Dr. Blair Spiller, 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, Inc. 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, Inc.

* 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, Inc. 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, Inc. 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, Inc.

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

COMPLAINTS:

If you have a complaint about how Holistic Chiropractic and Wellness, Inc. handles your PHI, or if you otherwise believe that your privacy rights have been violated by Holistic Chiropractic and Wellness, Inc., your complaint should be directed to:

Holistic Chiropractic and Wellness, Inc., 2251 Double Creek Dr, Suite #501 Round Rock, TX 78664 (512) 246-0220

Attention: Privacy Contact

If you are not satisfied with the manner in which Holistic Chiropractic and Wellness, Inc. 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, Inc. if you file a complaint.



OFFICE POLICIES

TO OUR VALUED PATIENTS:

Thank you for choosing Round Rock Health & Wellness Center for your care. We are committed to providing you with the best possible service. Please review our financial policy below. If you have any questions, please ask one of our staff to assist you with an explanation.

TIME OF SERVICE PAYMENT

Payment is required at the time services are rendered unless other arrangements have been made in advance by you and/or your insurance carrier. This includes applicable and estimated co-insurance and copayments under your insurance policy, deductible amounts under your insurance policy, and non-covered services. If there is a remaining balance due after your insurance carrier pays, you have **30 days** to make payment on the invoice. We urge you to keep your account current to avoid any misunderstandings with our office or cumulative buildup of your balance. RRHWC accepts cash, money orders, and most credit cards.

INSURANCE

As a courtesy to you, we will bill your insurance company for chiropractic services. It is your responsibility to provide us with information regarding the insurance we will be billing. If you do not have your insurance card(s) with you, your account will be considered "self-pay" until you provide us with the appropriate documents. Insurance coverage is a contract between you and your insurance carrier. **You are ultimately responsible for full payment of services rendered and knowing what your insurance will or will not pay.** Our front office staff will do their best to give you an **estimate** of what you'll owe each visit. Please be sure to inform the front office staff of any changes in your policy or information, and we will be happy to verify your benefits for you.

REFERRALS

Your insurance may require a prior authorization for some services before you can be seen by a chiropractor. It is your responsibility to make sure RRHWC has this authorization on file at the time of your visit. If the authorization is not provided, you may be asked to reschedule or pay for your visit at the time of service until the required documents are provided for submission to your insurance carrier.

FORMS REQUESTS

We are happy to provide you with hard copies or PDFs of any documentation you may need. If you need a flex receipt, superbill, letter of medical necessity, or any other documentation, please allow up to 48 hours for our office to complete.

NO-SHOW POLICY AND FEE

A missed appointment leaves an empty slot that could have been used by a patient in need of medical care. We therefore request that patients who are unable to keep their scheduled appointments notify us in advance so the time might be made available to someone else. To avoid any late cancellation fees, we require a minimum notice of one business day (or before 1pm on Saturday for a Monday appointment). Appointments that are cancelled without advanced notice, including same day cancellations, will be subject to a fee of \$25 for the first cancellation and up to the full service cost for repeated incidents.