

Central Illinois Natural Health Clinic Pediatric Registration & History Questionnaire

1. Patient Information

Patient Name: _____ Age: _____ Birthdate: _____
 Patient Social Security # (required for billing) _____ (Circle one) Gender: **M** **F**
 Home Address _____ City _____ State/Zip _____

Parent/Guardian Name: _____ **In event of emergency**
 Patient Home Phone: _____ Name: _____ Relationship: _____
 Patient Other Phone: _____ Home Phone _____ Work Phone: _____
 Who is your Medical Dr.? _____ Phone: _____

School Grade: _____ School Name: _____ Handedness Left Right

Please briefly describe the reason for your visit: _____

2. Referral Information

How did you hear about our office? (please check one of the following)

Yellow Pages Newspaper Sign Dr. _____ Patient _____
 Family _____ Website _____ Other _____

3. Birth History

Lbs _____ Weeks _____ Full Term Preterm

Vaginal C- section Reason for C-section _____

Medication during Pregnancy None Prenatal Vitamins Other – Please name: _____

4. Mom's Pregnancy	Postnatal Complications
<input type="checkbox"/> Uncomplicated <input type="checkbox"/> Early Labor <input type="checkbox"/> Hyper emesis (excessive vomiting) <input type="checkbox"/> Bleeding <input type="checkbox"/> Diabetes <input type="checkbox"/> Thyroid Problems <input type="checkbox"/> Pre-eclampsia	<input type="checkbox"/> None <input type="checkbox"/> Jaundice <input type="checkbox"/> Respiratory <input type="checkbox"/> Cardiac <input type="checkbox"/> Infections <input type="checkbox"/> Gastrointestinal <input type="checkbox"/> Hospitalized, How Long? _____

5. Developmental History
Rolled over at _____ Walked at _____ Sat at _____ Talked at _____ Has (s)he stopped or had regression of speech <input type="checkbox"/> Yes <input type="checkbox"/> No

6. Medical History

<input type="checkbox"/> Allergies: _____ <input type="checkbox"/> Asthma <input type="checkbox"/> Breath-holding spells <input type="checkbox"/> Chicken pox <input type="checkbox"/> Colic <input type="checkbox"/> Dehydration <input type="checkbox"/> Ear infection <input type="checkbox"/> many <input type="checkbox"/> Rarely <input type="checkbox"/> none <input type="checkbox"/> Eczema <input type="checkbox"/> Encephalitis <input type="checkbox"/> Head injuries <input type="checkbox"/> Headaches <input type="checkbox"/> Measles <input type="checkbox"/> Meningitis <input type="checkbox"/> Passing out (syncope) <input type="checkbox"/> Seizures <input type="checkbox"/> with fever <input type="checkbox"/> without fever	<p>Immunizations Check (✓) immunizations given and circle how far in the series.</p> <input type="checkbox"/> HIB 2mo 4mo 6mo 12-15mo <input type="checkbox"/> Pneumococcal 2mo 4mo 6mo 12-15mo <input type="checkbox"/> Diphtheria <input type="checkbox"/> Pertussis <input type="checkbox"/> Tetanus 2mo 4mo 6mo 6-18mo 4-6yrs 11yrs(tetanus only) <input type="checkbox"/> Measles <input type="checkbox"/> Mumps <input type="checkbox"/> Rubella 12-14mo 4-6yrs <input type="checkbox"/> Hep B birth to 2mo 1-4mo 6-18mo <input type="checkbox"/> Varicella (12mo) <input type="checkbox"/> Polio OPV or IPV 2mo 4mo 6-18mo 4-6yrs
<p>Other? Any reactions to immunizations? Describe please:</p> <p>_____</p> <p>_____</p>	
<p>Previous surgeries (please include dates):</p> <p>_____</p> <p>_____</p>	

7. Medications						
Name medication	Date started	Dose			Still taking it?	Date discontinued
		AM	Noon	PM		

8. Academic Performance

Excellent Average Poor Not applicable

Which areas are difficult? _____

9. Behavior

Excellent Variable Disruptive

Is there any history of:

Biting

Hitting

Head banging

Aggressiveness

Unable to comfort

Odd fascinations

Bed wetting

Stuttering

Teeth grinding at night

Teeth grinding in the day

Pulling own hair

Nursing difficulty

Sensitivity to

sound

touch

smells

lights

How is his/her play? Appropriate Inappropriate

How does (s)he interact with other children? Very well Average Poorly

Abnormal movements None Excessive turning Hand flapping

Sleep pattern Normal Difficulty falling asleep Frequent waking Nightmares Night terrors

Other: _____

Vision: Vision tested? Yes No If yes, what were the findings _____

10. Excessive fears

Water

Being alone

Dark

Night terrors

Thunder

Strangers

Animals. Which ones? _____

Other _____

* Would you like to receive our e-mail reminder appointments? Yes No

E-mail Address: _____

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.

Patient Signature _____

Adult Patient

Parent or Guardian

Spouse

Date _____

Review of Systems

Patient Name: _____ **Date of Birth:** _____

Please check any boxes for symptoms or conditions that you are **currently** experiencing, or have experienced **within the past 6 months**. The doctor will ask you for more detail during your visit.

General			
<input type="checkbox"/>	Weight change	<input type="checkbox"/>	Fever/chills
<input type="checkbox"/>	Fatigue	<input type="checkbox"/>	Sweating/Night sweats
<input type="checkbox"/>		<input type="checkbox"/>	Weakness
Skin			
<input type="checkbox"/>	Rashes	<input type="checkbox"/>	Itching
<input type="checkbox"/>		<input type="checkbox"/>	Hair/nail change
Head			
<input type="checkbox"/>	Headache	<input type="checkbox"/>	Injury
Eyes			
<input type="checkbox"/>	Vision/glasses	<input type="checkbox"/>	Blurring
<input type="checkbox"/>	Double vision	<input type="checkbox"/>	Pain
<input type="checkbox"/>		<input type="checkbox"/>	Floaters
<input type="checkbox"/>		<input type="checkbox"/>	Discharge
Nose			
<input type="checkbox"/>	Sinusitis	<input type="checkbox"/>	Discharge
<input type="checkbox"/>	Bleeding	<input type="checkbox"/>	Obstruction
<input type="checkbox"/>		<input type="checkbox"/>	Postnasal drip
Mouth/Throat			
<input type="checkbox"/>	Sores	<input type="checkbox"/>	Teeth
<input type="checkbox"/>	Gum bleeding	<input type="checkbox"/>	Hoarseness
<input type="checkbox"/>		<input type="checkbox"/>	Dentures
<input type="checkbox"/>		<input type="checkbox"/>	Taste
Pulmonary			
<input type="checkbox"/>	Short of breath	<input type="checkbox"/>	Wheezing
<input type="checkbox"/>	Chest pain	<input type="checkbox"/>	Cough
<input type="checkbox"/>		<input type="checkbox"/>	Coughing blood
Breasts			
<input type="checkbox"/>	Masses	<input type="checkbox"/>	Pain
<input type="checkbox"/>		<input type="checkbox"/>	Discharge
Cardiovascular			
<input type="checkbox"/>	Chest Pain	<input type="checkbox"/>	Sensation of heart beating or racing
<input type="checkbox"/>	Blue skin or lips	<input type="checkbox"/>	Murmurs
<input type="checkbox"/>	Pain in legs while walking	<input type="checkbox"/>	Ankle Swelling
<input type="checkbox"/>		<input type="checkbox"/>	Short of breath lying down
<input type="checkbox"/>		<input type="checkbox"/>	High blood pressure
Gastrointestinal			
<input type="checkbox"/>	Appetite changes	<input type="checkbox"/>	Difficult swallowing
<input type="checkbox"/>	Pain	<input type="checkbox"/>	Hernia
<input type="checkbox"/>	Constipation	<input type="checkbox"/>	Anal discomfort
<input type="checkbox"/>	Jaundice	<input type="checkbox"/>	Hemorrhoids
<input type="checkbox"/>		<input type="checkbox"/>	Indigestion
<input type="checkbox"/>		<input type="checkbox"/>	Blood in stool
<input type="checkbox"/>		<input type="checkbox"/>	Diarrhea
<input type="checkbox"/>		<input type="checkbox"/>	Nausea, Vomiting
Genitourinary			
<input type="checkbox"/>	Painful urination	<input type="checkbox"/>	Nighttime urination (more than twice/night)
<input type="checkbox"/>	Frequent urination	<input type="checkbox"/>	Urgency to urinate
<input type="checkbox"/>		<input type="checkbox"/>	Blood in urine
<input type="checkbox"/>		<input type="checkbox"/>	Incontinence

Sexual History			
<input type="checkbox"/>	Syphilis	<input type="checkbox"/>	Gonorrhea
<input type="checkbox"/>	Contraception	<input type="checkbox"/>	Chlamydia
<input type="checkbox"/>	Testicular pain/swelling	<input type="checkbox"/>	Herpes
<input type="checkbox"/>		<input type="checkbox"/>	Sores/Discharge
<input type="checkbox"/>		<input type="checkbox"/>	Impotence
Female-menses			
<input type="checkbox"/>	Menopause	<input type="checkbox"/>	Spotting
<input type="checkbox"/>	Cramps	<input type="checkbox"/>	Cycle duration/Amount
<input type="checkbox"/>		<input type="checkbox"/>	Irregularity
Endocrine			
<input type="checkbox"/>	Goiter (lump in neck)	<input type="checkbox"/>	Tremor
<input type="checkbox"/>	Heat/Cold intolerance	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>		<input type="checkbox"/>	Hormone therapy
Allergic			
<input type="checkbox"/>	Sensitivity to allergens	<input type="checkbox"/>	Asthma
<input type="checkbox"/>	Eczema	<input type="checkbox"/>	Hay fever
<input type="checkbox"/>		<input type="checkbox"/>	Hives
Bones, joints & muscles			
<input type="checkbox"/>	Injury	<input type="checkbox"/>	Swelling
<input type="checkbox"/>		<input type="checkbox"/>	Pain/Arthritis
Blood-lymphatic			
<input type="checkbox"/>	Anemia	<input type="checkbox"/>	Bleeding tendency
<input type="checkbox"/>	Transfusions	<input type="checkbox"/>	Lymph node enlargement/pain
Neurologic			
<input type="checkbox"/>	Fainting	<input type="checkbox"/>	Speech problem
<input type="checkbox"/>	Coordination problem	<input type="checkbox"/>	Convulsions / Seizures
<input type="checkbox"/>		<input type="checkbox"/>	Sensation problem
<input type="checkbox"/>		<input type="checkbox"/>	Paralysis or Weakness
Psychologic			
<input type="checkbox"/>	Memory loss	<input type="checkbox"/>	Mood changes
<input type="checkbox"/>	Anxiety/Depression	<input type="checkbox"/>	Phobia (fear)
<input type="checkbox"/>		<input type="checkbox"/>	Sleep problem
<input type="checkbox"/>		<input type="checkbox"/>	Drug/Alcohol abuse

Bowel Movements: _____ per (day) (week) *please circle*

Other (please list):

Name _____ Date of birth _____

Family History

Indicate below which of your blood relatives (parents, grandparents, and siblings) have had these health problems. Please indicate whether the problem is current (C) or was in the past (P).

Condition	Relative	Current (C) or Past (P)	Age if Alive	Age at Death
Alcoholism/Addiction				
Allergies, Hay Fever				
Alzheimer's Disease				
Arthritis				
Asthma				
Cancer (please list type)				
Depression				
Diabetes				
Epilepsy				
Heart Disease				
High Blood Pressure				
Kidney Disease				
Liver Disease				
Lung Disease				
Osteoporosis				
Parkinson's Disease				
Schizophrenia				
Skin Disease				
Stroke				
Other:				
Other:				

Social & Lifestyle

Sleep _____ hours/night. Quality: _____

Exercise Type _____

How often _____ How long each session _____

Support System (Family and Friends) good moderate poor (circle one)

Comments _____

Spirituality (Optional) Please describe any important religious, spiritual, or philosophical beliefs

My goals for treatment are (check all that apply): symptom relief (palliative care) correction of the cause of my condition enhance my overall level of wellness and vitality other _____

Is there anything in your life that you would like to stop doing start doing do better do differently? Please explain:

Patient Signature

Date

**Central Illinois Natural Health Clinic, Ltd.
1012 W. Fairchild Street Danville, IL 61832
(217) 443-4372**

**CHIROPRACTIC AND NATUROPATHIC MEDICINE
INFORMED CONSENT FOR TREATMENT OF MINOR CHILD**

CONSENT TO TREATMENT OF MINOR CHILD

I hereby authorize Dr. Andrew R. Peters and whomever he may designate as his assistants to administer treatment as he/she so deems necessary to my _____,
_____.

Dated on this day: _____, 20__

Signed: _____

Witnessed: _____

Central Illinois Natural Health Clinic, Ltd.
1012 W. Fairchild Street Danville, IL 61832
(217) 443-4372

CHIROPRACTIC AND NATUROPATHIC MEDICINE
INFORMED CONSENT FOR TREATMENT

I, _____, hereby authorize Andrew R. Peters, DC, ND and/or other licensed Doctors of Chiropractic, Physicians, or qualified support staff of Central Illinois Natural Health Clinic, Ltd., to perform the following specific procedures as necessary to facilitate my diagnosis and treatment:

Common diagnostic procedures: e.g., physical examination, venipuncture, Pap smears, radiography, laboratory, x-ray.

Physical Medicine: e.g., chiropractic manipulative therapy, soft tissue manipulation (massage, myofascial release), stretching, therapeutic exercise, physiotherapy (electrical stimulation, ultrasound, heat, ice, mechanical traction), hydrotherapy (therapeutic use of water)

Minor office procedures: e.g., dressing a wound, ear cleansing.

Medicinal use of nutrition: therapeutic nutrition, nutritional supplementation.

Botanical medicine: botanical substances may be prescribed as teas, alcoholic tinctures, capsules, tablets, creams, plasters, or suppositories.

Homeopathic medicine: the use of highly dilute quantities of naturally occurring plants, animals and minerals to gently stimulate the body's healing responses.

Lifestyle counseling and hygiene: diet therapy, promotion of wellness including recommendations for exercise, sleep, stress reduction and balancing of work and social activities.

I recognize the potential risks and benefits of these procedures as described below:

Potential risks include, but are not limited to: allergic reactions to prescribed herbs and supplements, side effects of natural medications, inconvenience of lifestyle changes, injury from injections, venipuncture or procedures. Potential risks of physical medicine include, but are not limited to: fracture, disc injury, stroke, dislocation, sprain/strain, increased pain.

Potential benefits: restoration of health and the body's maximal functional capacity, relief of pain and symptoms of disease, assistance in injury and disease recovery, and prevention of disease or its progression.

Notice to Pregnant Women: All female patients must alert the doctor if they know or suspect that they are pregnant as some of the therapies used could present a risk to the pregnancy.

With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by Central Illinois Natural Health Clinic, Ltd., or any of its personnel regarding cure or improvement of my condition. I understand that I have the right to an explanation of: my suspected diagnosis; the nature, purpose, and potential benefit of the proposed care; the inherent risks, complications, potential hazards, or side effects of the treatment or procedure; the probability of success; reasonable available alternatives to the proposed treatment/procedure; the possible consequences if treatment or advice is not followed and/or nothing is done. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by myself or my representative or unless it is required by law. I understand that I may look at my medical record at any time and can request a copy of it by paying the appropriate fee. I understand that my medical record will be kept for a minimum of three, but no more than ten years after the date of my last visit. I understand that information from my medical record may be analyzed for research purposes, and that my identity will be protected and kept confidential. I understand that any questions I have will be answered by my practitioner to the best of his/her ability.

Date

Original to: Chart

Copy to: Patient (if requested)

Signature of Patient

Signature of Patient Representative or Guardian

Signature of CINHC Representative

Central Illinois Natural Health Clinic
1012 W. Fairchild Street • Danville IL, 61832
(217) 443-4372

Financial Policy

Thank you for choosing us as your health care provider. We are committed to the success of your treatment. The following is a statement of our Financial Policy, which we require that you read and sign prior to treatment. If at any time you have questions regarding any treatment, fee, or service, please discuss them with us promptly and frankly. We will make every effort to avoid a misunderstanding or rectify an injustice.

INSURANCE

As a courtesy to you, we will bill your insurance carrier for you. All co-payments, deductibles, and payments for supplements, supports, and other “non-covered” services are due at time of service unless prior arrangements have been made. Payments may be made by cash, check, Visa, MasterCard, or Discover. Any unpaid balances 90 days and over will be charged interest of 1.0% per month. Returned checks will be charged a \$25 fee (in accordance with 810 ILCS 5/3-806). If you are unable to pay in full, it is your responsibility to contact our billing department to set up an agreeable payment plan. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract.

When possible, we will call to verify benefits on your insurance. However, the benefits quoted to us by your insurance company are **not a guarantee of payment. Payment will be due by you at the time of service for any non-covered services, deductibles or co-pays.**

UCR (USUAL AND CUSTOMARY RATES)

Our practice is committed to providing the best treatment possible for our patients, and we charge what is usual and customary for our area. You are responsible for payment in full, regardless of any insurance company’s arbitrary determination of usual and customary rates.

INJURIES/ACCIDENTS INVOLVING LITIGATION

We will make every effort to recover our fees from all available sources, including your health insurance and any med-pay benefits that are available on your auto insurance policy. We will then wait to collect any unpaid balances until after a settlement is reached. **It must be understood, however, that the payment of the balance is ultimately your responsibility.**

WORKER’S COMPENSATION

Our office will file worker’s compensation claims. It is your responsibility to contact your employer to establish a worker’s compensation claim. If the claim is denied, we will bill your personal health insurance carrier. If the claim is unsettled or unpaid within 90 days, you will receive a statement from our office.

*** CLASSICAL HOMEOPATHY ***

This is more than an “ordinary” patient visit due to the extended time involved in taking your detailed history from a homeopathic perspective (2-3 hours). Because of the extensive nature of the homeopathic interview, many insurance carriers do not offer full reimbursement. Therefore, we do not submit these charges to insurance. We request payment either at time of service or according to a written payment plan agreement. We will be happy to supply you with a detailed receipt that you may submit to your insurance company. Please inquire about pricing and payment plans available.

PATIENTS WITHOUT INSURANCE

We request that 100% of the first visit be paid at the time of the visit. On other visits, payment may be made at the end of the week if you sign a credit guarantee form. We are happy to accept your check, Master Card, Visa, or Discover.

MINOR PATIENTS

An adult must accompany the minor at the time of the first visit. The adult accompanying the minor is responsible for payment of the account.

MEDICARE PARTICIPANTS

We accept assignment from Medicare. The check is usually sent directly to our office in payment of the services that Medicare will cover, which for Chiropractors is ONLY manual manipulation of the spine. Medicare pays 80% of the allowable fee once the deductible of \$135.00 has been met. You are required to pay the deductible and the remaining 20%, as well as any non-covered services (exams, labs, supplies, etc.). Our office completes and files the forms for Medicare at no charge.

SECONDARY INSURANCE

Please inform us of any secondary insurance you may have. We will assist you if you need help in filing.

MEDICAL RECORDS

You have the right to a copy of your medical records. The fee for copy is a \$24.44 handling charge, plus \$0.92/page for the first 25 pages, plus \$0.61/page for pages 26-50, plus \$0.31/page thereafter (735 ILCS 5/8-2006).

MISSED APPOINTMENTS

We require 24 hours notice for cancellation of all appointments. There will be a \$10 charge to the patient for all appointments that are missed and not canceled.

I have read and understand the Financial Policy of the Central Illinois Natural Health Clinic, Ltd. I understand that I am ultimately responsible for the payment of any services or products received at this office. I also understand that I will be responsible for any fees related to collecting my unpaid balance, including a 40% collection agency fee, and/or reasonable attorney fees.

Signed _____ Date _____

(Parent or Guardian if patient is under 18 years of age) Patient's Name (printed) _____

CINHC Representative Signature: _____ Date: _____

Notice of Privacy Practices: Acknowledgement of Receipt

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting the privacy officer.

Our *Notice of Privacy Practices* describes in more detail how your health information may be used and disclosed, and how you can access your information.

By my signature below I acknowledge receipt of the Notice of Privacy Practices.

Signature of patient or authorized representative

Date

Printed name if signed on behalf of patient

Relationship (parent, legal guardian, personal representative, etc.)

(Notation, if any, by staff)

Patient has or will receive a copy of Notice of Privacy Practice in their Patient Binder.

This form will be retained in your medical record.

Central Illinois Natural Health Clinic Insurance Information

1. PRIMARY INSURANCE

Please give your Insurance card to the Receptionist

Insurance Carrier's Name _____
Insured's Group# (Plan, Local or Policy #) _____
Insured's ID Number _____

Are you the primary card holder? Yes No *If you answered "No" Please complete the following information*

Please note all information below is required for insurance billing.

Insured's Name (Last, First, MI) _____
Relationship to Patient _____
Insured's Date of Birth _____
Insured's Social Security number _____
Insured's Employer _____
Insured's ID Number _____
 Male Female
Insured's Mailing Address if Different from Patient Address _____ Insured's Phone () - _____

2. ADDITIONAL INSURANCE

Please give your Insurance card to the Receptionist

Insurance Carrier's Name _____
Insured's Group# (Plan, Local or Policy #) _____
Insured's ID Number _____

Are you the primary card holder? Yes No *If you answered "No" Please complete the following information*

Please note all information below is required for insurance billing.

Insured's Name (Last, First, MI) _____
Relationship to Patient _____
Insured's Date of Birth _____
Insured's Social Security number _____
Insured's Employer _____
Insured's ID Number _____
 Male Female
Insured's Mailing Address if Different from Patient Address _____

Insured phone if different from Patient () - _____

3. ASSIGNMENT & RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with, _____ and assign directly to Central Illinois Natural Health Clinic, Ltd. all insurance benefits. I understand that I am Financially responsible for all charges whether or not paid by insurance. I also authorize Central Illinois Natural Health Clinic, Ltd. or insurance company to release any information required in order to process my claims.

Signature of Patient, Guardian or Personal Representative

Date

Please print name of Patient, Guardian or Personal Representative

Date

Central Illinois Natural Health Clinic, Ltd.

Dr. Andrew R. Peters, DC, ND
1012 W. Fairchild Street Danville, IL 61832
Phone: 217-443-4372
Fax: 217-443-0452

Authorization for the Release of Medical Records

This authorization will be effective for six months after the date signed, unless canceled in writing. I understand that the cancellation will have no effect on information released prior to receiving the cancellation. A copy of this authorization is as valid as the original.

Patient Name (please print) _____
Patient Date of Birth _____
Patient Address _____
City/State/Zip _____

Signature of Patient or Legal Representative/Relationship **Date:** _____

If signing for a minor patient, I hereby state that my parental rights have not been revoked by a court of law.

Notice to recipient of information: This information has been disclosed to you from confidential records, which are protected by law. Unless you have further authorization, laws may prohibit you from making any further disclosures of this information without the specific written consent of the patient or legal representative.