Pediatric Patient Information

Name: _____ Middle: _____ Last: _____

Date of Birth:_____ Gender:_____ Last 4 of SS#:_____

Address:_____ Apt/Unit: _____

City:_____ State:_____ Zip:_____

Parent 1/Guardian 1/Mother Full Name:_____ Date of Birth: _____

Address (if different):_____ Apt/Unit: _____

Cell Phone:_____Home Phone:_____ Email: _____

Parent 2/Guardian 1/Mother Full Name:_____ Date of Birth: _____

Address (if different):_____ Apt/Unit: _____

Cell Phone:_____Home Phone:_____ Email: _____

Primary Doctor:_____ Phone #:_____

Referring Doctor:_____ Phone #: _____

Consent of Treatment

The patient/legal guardian authorizes The American Institute of Balance (AIB) staff to administer appropriate testing and/or treatment for the patient's diagnosis/rehabilitation. The patient/legal guardian agrees that no guarantee or assurance has been made as to the results that may be obtained from the services rendered.

Consent to Release Medical Information

I authorize AIB to releasee any information acquired in connection with my diagnostic/treatment services including, but not limited to, diagnosis and clinical records, to myself, my insurance(s), physician(s), and:_____

Assignment of Insurance Benefits

I hereby authorize payments to be made directly to The American Institute of Balance.

Primary Insurance Name:_____ ID #:_____ Group #: _____

Primary Insurance Card Holder Name_____

Card Holder's Date of Birth:_____ Last 4 Digits of Card Holder's Social Security: ____ ____ ____ ____

Secondary Insurance Name:_____ ID #:_____ Group #:_____

Guarantee of Payment

I agree to pay any charges that my insurance does not pay. I am responsible to pay any uncovered portion on the date services are rendered. I am responsible for any incurred costs on overdue balances including, but not limited to, late fees, interest fess, legal fees, and collection agency fees.

Cancellation/No-Show Policy

I understand that my appointment is a reservation of time with a skilled health professional. Insufficient notice of missing an appointment detracts from my ability to get fully well and affects other patients as well. Appointments cancellations without sufficient notice (<24 hours) will be charged a $25. My insurance does not cover these fees and it will be my responsibility to pay. If I repeatedly neglect my appointments, the office may dismiss me as a patient.

I hereby certify that I understand these rights set forth.

I acknowledge that I have been informed of AIB's Privacy Practices as required by the Health Insurance Portability and Accountability Act (HIPAA). I have the option to request full details regarding the privacy of my information. *A current copy of AIB's Privacy Practices is available to you upon request.*

Legal Guardian Signature: _____ Date: _____

Please Print Name: _____ Relationship:_____

The American Institute of Balance®

Pediatric Balance Questionnaire

PATIENT NAME:_____

DOB: _____ DATE:_____

I. History of Present Illness

1. Briefly describe the reason for today's visit:_____
2. When was the problem first noticed? _____
3. Do the symptoms occur in attacks? ☐ YES ☐ NO
   a. If so, how many have you observed? _____
   b. If so, when was the last attack observed? _____
   c. If so, what symptoms occur during the attack? _____
4. Are the symptoms constant? ☐ YES ☐ NO
   a. If so, are the symptoms improving? ☐ YES ☐ NO
   b. If so, are the symptoms worsening? ☐ YES ☐ NO

II. Pregnancy/Birthing History

Length of pregnancy: _____ weeks Child's birth weight: _____ lbs. _____ oz.

1. Was the child birthed vaginally or via caesarian section? (circle one)
2. Were there any complications/illnesses during pregnancy? ☐ YES ☐ NO
   a. If so, please explain: _____
3. Were there any complications during the birth? ☐ YES ☐ NO
   a. If so, please explain: _____
4. Did the child spend any time in the hospital/NICU? ☐ YES ☐ NO
   a. If so, for how long and please explain why:_____
   b. If so, were they given any medications? (please list) ☐ YES ☐ NO

III. General Health History

1. At what age did the child meet the following milestones?
   a. Sat alone _____ b. Crawled _____ c. Stood alone _____ d. Walked alone _____
2. Does the child have motion intolerance or car sickness? ☐ YES ☐ NO
3. Does the child have hearing loss/suspected hearing loss? ☐ YES ☐ NO
   a. If so, at what age did this begin? _____
4. Has the child been diagnosed or treated for: (check all that apply)

__ Coordination problems	__ Cerebral Palsy	__ Cognitive delays
__ Recurrent headaches	__ Head injury	__ Convulsions/seizures
__ High fevers	__ Meningitis	__ Measles
__ Attention deficit disorder	__ Eye problems	__ Allergies
__ Spectrum Disorder	__ Torticollis	Other: _____
__ Chicken pox	__ Mumps	

The American Institute of Balance®

Pediatric Balance Questionnaire

IV. Family History

1. Is there a familial history of migraine? ☐ YES ☐ NO
   If so, which family member(s)? _____
2. Does the child have any siblings? ☐ YES ☐ NO
   If "YES" please fill out the following:
   a. Age of sibling 1 _____
      Were there any complications/illnesses during the pregnancy or birth? ☐ YES ☐ NO
   b. Age of sibling 2 _____
      Were there any complications/illnesses during the pregnancy or birth? ☐ YES ☐ NO
   c. Age of sibling 3 _____
      Were there any complications/illnesses during the pregnancy or birth? ☐ YES ☐ NO
   d. Age of sibling 4 _____
      Were there any complications/illnesses during the pregnancy or birth? ☐ YES ☐ NO
   e. Age of sibling 5 _____
      Were there any complications/illnesses during the pregnancy or birth? ☐ YES ☐ NO
   If you answered "YES" to any of the above, please explain: _____

   _____

   _____

5. Have any of the child's siblings been diagnosed/treated for: (check all that apply)

__ Coordination problems __ Spectrum Disorder __ Convulsions/seizures
__ Recurrent headaches __ Cerebral Palsy __ Migraine
__ Attention deficit disorder __ Cognitive delays Other: _____

V. Education

1. What grade is the child in? _____
2. Has the child ever repeated a grade? ☐ YES ☐ NO
   a. If so, which grade and why? _____
3. Does your child like school? ☐ YES ☐ NO
4. Please indicate the subjects that are difficult for your child, if any: _____
5. Has your child ever received any special help at school?
   a.If so, please describe: _____
6. Has your child been a behavioral problem at school? ☐ YES ☐ NO
   a. If so, please describe: _____
7. Does the child participate in any afterschool activities? ☐ YES ☐ NO
   a. If so, please describe: _____

VI. Additional Comments and/or Concerns

_____

_____

_____

This form was completed by: _____ Date: _____
Relationship to child: _____