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CHIROPRACTIC

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Pediatric Intake Form

Date:_____

Patient Name: _____ Nickname: _____

Date of Birth: ____/____/____ Gender: _____ Weight:_____ Height:_____

Parent's Name: _____

Address: _____

City: _____ State: _____ Zip:_____

Mom Cell: _____ Dad Cell:_____

Email: _____

Name of Insurance Company:_____ Policy #:_____

Referred by:_____

Name of School _____

Hobbies/Sports/Interests: _____

Sibling(s) Name/Age(s):_____

Health History

Name of Pediatrician: _____

Other Providers: _____

Other Diagnosed Conditions:_____

Medications/Supplements:_____

Prior Surgeries:_____

Please explain the reason for today's visit:

_____

_____

_____

Authorization for Care of Minor

I hereby authorize this office and its doctors to administer care for my minor daughter/son _____as they deem necessary. I clearly understand and agree that I am personally responsible for payment of all fees charged by this office. This authorization also extends to all other doctors and office staff members. As of this date, I have the legal right to select and authorize health care services for the minor child named above.

Signed:_____ Witnessed:_____

Date:_____

Dr. Lisa Goodman, DC, CCSP - Dr. Jace Buzek,DC, CCSP - Dr. Cynthia Mangla, DC
1313 South Clarkson Street Unit 1, Denver, Colorado 80210 303-744-7100 www.washparkchiro.com

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Financial Policy

Washington Park Chiropractic is an out-of-network provider with all health insurance companies. It is your responsibility to verify if you have benefits for out-of-network chiropractic before your first appointment. Washington Park Chiropractic can also check your benefits prior to or the day of your visit. All patient responsible payment is due at the time of service.

No-Show/Cancellation Policy

To better serve all of our patients and ensure that they have a fair opportunity to have an appointment as promptly as possible.

Please observe our cancellation policy for chiropractic and massage appointments.

We require a minimum 24-hour notice to cancel or reschedule all massage and new patient chiropractic appointments. We also require at least 2 hours notice for regular chiropractic appointments.

Fees

Chiropractic: no-shows/late cancels may be billed $25 for the first missed appointment and full price for subsequent missed appointments. Your card may be automatically charged. New patient missed appointments may be billed at half the price of the appointment.

Massage: no-shows/late cancels may be billed for half of the price of the massage for the first missed appointment and full price for any subsequent missed appointments.

Please arrive on time for your appointment. If you know you will be late, please call to verify that the doctor will be able to devote your full scheduled time to you. If it is best, we will reschedule your appointment.

_____ _____

Patient's Signature Date

_____

Patient's Name (print)

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Child History- 3 years to 11 years

Health History

Yes No

- ☐ ☐ Does your child ever complain of back or neck pain? _____
- ☐ ☐ Pain in the legs or arms? _____
- ☐ ☐ Asthma? _____
- ☐ ☐ Headaches? _____
- ☐ ☐ Is your child allergic to anything? _____
- ☐ ☐ Has your child had any ear infections? At what age did each infection occur? _____

  _____
- ☐ ☐ Which side does your child's ear infections normally occur? ☐ Right ☐ Left ☐ Both
- ☐ ☐ Has your child had any other illnesses? Please list each illness and approximate date: _____

  _____
- ☐ ☐ Is your child presently receiving any medications? _____

  _____
- ☐ ☐ Has your child ever been to a hospital or emergency room? _____
- ☐ ☐ Has your child been vaccinated? If yes, ☐Regular Schedule ☐ Delayed Schedule
- ☐ ☐ Do you have any other concerns about your child's health? _____

  _____

Nutrition

Yes No

- ☐ ☐ Do you have any concerns about your child's diet? _____
- ☐ ☐ Does your child have any food allergies? _____
- ☐ ☐ Have any persistent or intermittent skin rashes? _____
- ☐ ☐ Is your child receiving any vitamin supplements? _____
- ☐ ☐ Does your child have a bowel movement each day? _____

Trauma

Yes No

☐ ☐ Has your child had any recent falls or trauma? _____

Describe the trauma and date it occurred: _____

_____

☐ ☐ Has your child ever fallen from a bicycle, skateboard, scooter, rollerblades or similar?

☐ ☐ Ever fallen down stairs or from a significant height? _____

☐ ☐ Ever had a bone fracture or joint dislocation? _____

☐ ☐ Ever had any other trauma or injuries? _____

About your child's lifestyle:

What grade in school? _____

How does your child carry their school supplies? _____

Is your child right or left handed? _____

What sports do they play? What position? _____

How many days/how long does your child practice each sport? _____

_____

Have they had any injuries from playing sports? _____

What hobbies do they have? _____

How many hours do they watch television each day? _____

How many hours do they use devices each day? _____

How often do they play video games each day? _____

How many hours of sleep do they get each night? _____

Do they have trouble reading or paying attention at school? _____

Do they wear glasses or contacts? _____

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Informed Consent

I, the undersigned, have voluntarily requested that the Doctors and/or other providers at Washington Park Chiropractic assist me in the management of my health concerns. I understand and agree to all policies and terms provided in the Office Policies and Procedures.

Meet The Doctors

Dr. Lisa Goodman, DC, CCSP, CACCP
2006 Graduate of Palmer College of Chiropractic West, San Jose CA
Certified Chiropractic Sports Physician
Certified by the Academy Council of Chiropractic Pediatrics
Webster, Prenatal Certified
Graston Certified, FAKTR Certified (Instrument Assisted Soft Tissue Mobilization)

Dr. Jace Buzek, DC, CCSP, CACCP
2010 Graduate of Palmer College of Chiropractic, Davenport IA
Certified Chiropractic Sports Physician
Certified by the Academy Council of Chiropractic Pediatrics
Webster, Prenatal Certified
Graston Certified, FAKTR Certified (Instrument Assisted Soft Tissue Mobilization)

Dr. Cynthia Mangla, DC
2015 Graduate of Palmer College of Chiropractic Florida, Port Orange FL
Webster, Prenatal Certified

Chiropractic

Chiropractic healthcare is primarily concerned with the relationship between structure (primarily of the spine) and function (primarily of the nervous system). The doctor of chiropractic evaluates the patient using standard examination and testing procedures (such as orthopedic and neurologic evaluation and possibly x-rays) along with specialized chiropractic evaluation including observation, inspection, auscultation and palpation. The chiropractic examination focuses on structural or functional abnormalities called segmental dysfunction. Segmental dysfunction exists when one or more vertebrae in the spin or bones in the extremity are fixated sufficiently to result in damage or irritation to either nearby nerves, joints, and or tissues such as muscles and ligaments. The primary goal of chiropractic treatment is to remove the fixation. This is accomplished by performing a procedure unique to chiropractic called an adjustment. An adjustment involved the application of a quick, precise force directed over a very short distance to a specific vertebrae or bone. Adjustments are usually performed by hand, but may use a hand-guided instrument. In addition to adjustments, other treatments used by chiropractors include physiotherapy modalities (ice, heat, soft tissue manipulation), nutritional recommendations and rehabilitative procedures.

As is the case with all health care interventions, the benefits of care must be weighted against the inherent risks and limitations of receiving treatment. Chiropractic treatments are one of the safest interventions available to the public as evidenced by malpractice statistics. While there are risks involved with treatment, these are seldom great enough to contraindicate care.

Manual Therapy
A large part of our treatment involves manual therapy performed by hand or using instruments. Manual Therapy is a generally performed to increase range of motion, reduce scar tissue, and treat sprains and strains. Some common side effects of Manual Therapy include soreness and bruising.

Results from Treatment
I understand that there are beneficial effects associated with these treatment procedures including decreased pain, improved mobility and function, and reduced muscle spasm. However, I appreciate there is no certainty that I will achieve these benefits. I realize that the practice of medicine as well as chiropractic, is not an exact science and I acknowledge that no guarantee has been made to me regarding the outcome of these procedures. I agree to the performance of these procedures by my doctor and such other persons of the doctor's choosing.

Possible Risks & Side Effects from Treatment
One research study indicated that within the first 2 months of care, approximately half of patients report some "reaction" to chiropractic treatment. Of those who reported a reaction, the following were the most commonly reported reactions to initial chiropractic care:
Local Discomfort (53%)
Headache (12%)
Tiredness (11%)
Radiating Discomfort (10%)
Most appeared within 4 hours of treatment and resolved within 24 hours.
Rare, yet possible side-effects / Complications:
Rib Fracture
Disc Herniation
Cauda Equina Syndrome (1 case per 100 million adjustments)
Compromise of the vertebrobasilar artery (ie. Stroke) (1 case per 400,000 to 1 million cervical spine adjustments)

Stretching & Exercise Disclaimer
Additional risks are present with stretching and exercise. These risks are increased if you have had surgery or have had a surgical implant or device or history of dislocation. Please consult your treating and or operating physician prior to engaging in any stretching or exercise program.

Alternative Treatments Available
Reasonable alternatives to these procedures have been explained to me including:
Medications: I am aware that long-term use or overuse of medication is always a cause for concern. Drugs may mask pathology, produce inadequate or short-term relief, undesirable side-effects, physical or psychological dependence, and may have to be continued indefinitely. Some medications may involve serious risks that I should discuss with my medical doctor.
Rest/Exercise: Simple rest is not likely to reverse pathology, although it may temporarily reduce inflammation and pain. The same is true of ice, heat, or other home therapy. Prolonged bed rest contributes to weakened bones and joint stiffness. Exercises are of value but are not corrective of injured nerve and joint tissues.
Surgery: Surgery may be necessary for conditions such as joint instability or serious disk rupture, among others. Surgical risks may include unsuccessful outcome, complications, pain or reaction to anesthesia, and prolonged recovery.
Non-treatment: I understand the potential risks of refusing or neglecting care may include increased pain, scar/adhesion formation, restricted motion, possible nerve damage, increased inflammation, and worsening pathology. The aforementioned may complicate treatment making

future recovery and rehabilitation more difficult and lengthy.

Please circle the answer to all questions below to help us determine possible risk factors:

1. Have you ever had an adverse (ie. bad) reaction to or following chiropractic care? Y N
2. Have you ever been diagnosed with osteoporosis or osteopenia? Y N
3. Do you take corticosteroids (ie. Prednisone)? Y N
4. Have you ever been diagnosed with a fracture of the spine? Y N
5. Have you ever been diagnosed with cancer? Y N
6. Do you take Warfarin (coumadin), heparin or other "blood thinners"? Y N
7. Have you ever had a stroke or TIA (transient ischemic attack)? Y N
8. Have you ever been diagnosed with any of the following?

a. Rheumatoid Arthritis Y N
b. Reiter's Syndrome, Ankylosing Spondylitis, Psoriatic Arthritis Y N
c. Giant Cell Arteritis Y N
d. Ligamentous Hypermobility (Marfan's, Ehler's Danlos) Y N

9. Have you ever become dizzy while turning your head? Y N
10. Have you ever had spinal / back surgery? Y N
11. Have you ever been diagnosed with spinal stenosis? Y N
12. Have you ever had any of the following problems?

a. Sudden weakness in the arms of legs? Y N
b. Numbness in the genital area? Y N
c. Recent inability to urinate or lack of control when urinating? Y N

A thorough health history and physical examination will be performed on me to minimize the risk of any complication from treatment and I freely assume these risks.

I have read or have had read to me the above explanation of chiropractic treatment. The doctor has also asked me if I want a more detailed explanation; but I am satisfied with the explanation and do not want any further information. I have made my decision voluntarily and freely. To attest to my consent to these examination and treatment procedures, I hereby affix my signature to this Informed Consent document.

Signature of patient (or guardian) _____ Date _____

Doctor's Signature _____ Date _____
I explained the procedures, alternatives, and risks in conference with the patient.

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HIPAA Privacy Practices – Patient Reception Form

I have received or reviewed the privacy practice notice for Washington Park Chiropractic, and understand the situations in which this practice may need to utilize or release my medical records. I also understand that I agreed to the use of those records when I initially initiated care at this office on my first visit, whenever that may have occurred.

I understand that this office will properly maintain my records, and will use all due means to protect my privacy as outlined in this privacy practices statement.

_____ _____

Patient/Guardian Signature Date

_____

Print Patient Name

Exception and Records Release

I allow the doctors and staff at Washington Park Chiropractic to discuss my treatment and diagnosis with the following doctors, health care professionals, coaches, lawyers, spouses, etc.

Name	Title
_____	_____
_____	_____
_____	_____
_____	_____

_____ _____

Patient/Guardian Signature Date

_____

Print Patient Name