

# washington park CHIROPRACTIC



## Pediatric Intake Form

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_  
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:<br>_____<br>_____<br>_____ |
|---|

### 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: \_\_\_\_\_



## 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)

# washington park CHIROPRACTIC



Name \_\_\_\_\_ Age \_\_\_\_\_

## Newborn History- Birth to 2 months

How many hours does your baby sleep between feedings? During the day \_\_\_\_\_ Night \_\_\_\_\_

### Does baby

Yes No

- Fall asleep easily? \_\_\_\_\_
- Have a preferred sleeping position? \_\_\_\_\_
- Cry if you change this sleeping position? \_\_\_\_\_
- Sleep in a crib? If no, please choose: co-sleep, bassinet, swing, other: \_\_\_\_\_
- Have any feeding difficulties? \_\_\_\_\_
- Breast feed? Currently \_\_\_\_\_ or How Long ? \_\_\_\_\_ weeks/months  
If no, which formula is used? \_\_\_\_\_
- Have a one-sided breast-feeding preference? Preferred breast: Left / Right
- Frequently spit-up after feeding? \_\_\_\_\_
- Cry excessively? For how many hours per day? \_\_\_\_\_
- Pass a lot of intestinal gas? \_\_\_\_\_
- Have a preferred head position? \_\_\_\_\_
- Frequently arch his/her head, neck, or body backwards? \_\_\_\_\_
- Cry or become irritable during a diaper change? \_\_\_\_\_

### Has baby

Yes No

- Ever had a fever? \_\_\_\_\_
- Had any falls? \_\_\_\_\_
- Had any rashes, bruises, skin problems? \_\_\_\_\_
- Has baby been in a car accident, or near miss? \_\_\_\_\_
- Has baby had any other trauma? \_\_\_\_\_
- Has your baby been vaccinated? If yes, choose: Regular schedule / Delayed schedule

Do you have any other concerns you wish to discuss? \_\_\_\_\_

# washington park CHIROPRACTIC



## 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 spine 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 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 or 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.



**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