

# Be Well Chiropractic & Health- Pediatric Intake

255 Hope Street Providence, RI 02906

## Welcome

Please fill out the following information to the best of your ability so that we can provide the best service to you. After a thorough examination, you and the doctor will decide upon the best course of action for the care of your child. If we do not believe that chiropractic care is the best option, we will refer you to another health care provider, if appropriate.

Child Name \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_ Age \_\_\_\_\_ SS# \_\_\_\_\_

Date of Birth \_\_\_\_\_ Gender \_\_\_\_\_ Preferred Pronoun \_\_\_\_\_

Parent/Guardian Name \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address (if different than above) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_ Email address \_\_\_\_\_ Sex (M) (F)

Occupation \_\_\_\_\_ SS# \_\_\_\_\_

Marital Status \_\_\_\_\_ Number of other Children \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone Number \_\_\_\_\_

Referred by \_\_\_\_\_

Pediatrician's name and date of last check-up \_\_\_\_\_

Please state the main reason for your visit. \_\_\_\_\_

\_\_\_\_\_

Please list any known allergies \_\_\_\_\_

Please list any medication, vitamins or herbs your child is taking. If you are breastfeeding please also list anything you are taking as well. \_\_\_\_\_

\_\_\_\_\_

### Mother's history (Antenatal):

Please circle if any of the following occurred during the mother's pregnancy:

- |              |                 |          |
|--------------|-----------------|----------|
| Infections   | Alcohol usage   | Bleeding |
| Preeclampsia | Tobacco usage   | Anemia   |
| Toxemia      | Drug usage      |          |
| Diabetes     | Physical injury |          |

Circle: (Rhesus status )RhD + -

**Natal/Perinatal & Postnatal History:**

Birth weight & height \_\_\_\_\_

Any delivery intervention (ie. Forceps, cesarean section) \_\_\_\_\_

Was/is your child breastfed? Y N

Please circle if your child has or had any of the following illnesses:

- |                |                 |        |
|----------------|-----------------|--------|
| Chicken pox    | Hernia          | Colic  |
| Measles        | Mumps           | Asthma |
| Whooping cough | Reubella        |        |
| Otitis media   | Rheumatic fever |        |

Please list any previous dislocations or fractures (broken bones), or any surgeries.

\_\_\_\_\_

Please list any medical conditions not listed above. \_\_\_\_\_

\_\_\_\_\_

**Acceptance as a Patient**

I understand and agree that the doctors of New England Chiropractic Center have the right to refuse to accept my child as a patient at any time before treatment begins. The taking of a history and the conducting of a physical examination are not considered treatment, but are part of the process of information gathering so that the doctor can determine whether to accept her/him as a patient. When she/he is accepted as a patient, I assign full benefits to New England Chiropractic Center. I understand that New England Chiropractic Center reserves the right to charge me in the amount of \$48.00 for any missed appointments without 24 hours notice.

\_\_\_\_\_  
Parent/Guardian Signature      Date

**Release of Records**

I hereby authorize you, your employees and agents to furnish to all pertinent healthcare provider/person(s) and health insurance companies, all records and reports, including X-rays and photostatic copies, abstracts or excerpts of all records and any other information he/she/they may request relating to any examination, treatment or opinion concerning any condition that my dependant may have had in the past, now have, or may have in the future.

\_\_\_\_\_  
Parent/Guardian Signature      Date

Patient Name: \_\_\_\_\_

• **The nature of the chiropractic adjustment.** The doctor may use her hands or a mechanical device upon your body in such a way as your joints. That may cause an audible “pop” or “click,” which signifies gases moving through those joints allowing for the movement to occur. You may feel or sense movement.

• **The material risks inherent in chiropractic adjustment.** As with any health care procedure, there are certain complications which may arise during a chiropractic adjustment. Those complications include: fractures, disc injuries, dislocations, and muscle strain, Horner’s syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment.

• **The probability of those risks occurring.** Fractures are rare occurrences and generally result from some underlying weakness of the bone which we check for during the taking of your history and during examination and X-ray. Stroke has been the subject of tremendous disagreement within and without the profession with prominent authority stating that there is at most a one-in-a-million chance of such an outcome. Since even that risk should be avoided if possible, we employ tests in our examination which are designed to identify if you may be susceptible to that kind of injury. The other complications are also generally described as “rare.”<sup>1</sup> Haldeman, Scott, D.C. M.D.

• **Ancillary treatment.** The doctor may offer treatment options, aside from chiropractic manipulation, that may include physiotherapy, rehabilitation, and nutritional and lifestyle counseling. Such further treatment options will be discussed with you after a thorough examination and report of findings has been completed.

• **Other treatment options exist for your condition. The material risks inherent in such options and the probability of such risks occurring include:**

• **Overuse of over-the-counter medications** produces undesirable side-effects. If complete rest is impractical, premature return to work and household chores may aggravate the condition and extend the recovery time. The probability of such complications arising is dependent upon the patient’s general health, severity of the patient’s discomfort, pain tolerance and self-discipline in not abusing the medicine. Professional literature describes highly undesirable effects from long term use of over-the-counter medicines.

• **Prescription muscle relaxants and pain-killers** can produce undesirable side effects and patient dependence. The risk of such complications arising is dependent upon the patient’s general health, severity of the patient’s discomfort, pain tolerance, self-discipline in not abusing the medicine and proper professional supervision.

• **Hospitalization** in conjunction with other care bears the additional risk of exposure to communicable disease, iatrogenic (doctor induced) mishap and expense. The probability if iatrogenic mishap is remote, expense is certain, exposure to communicable disease is likely with adverse result from such exposure dependent upon variables.

• **The risks inherent in surgery** include adverse reaction to anesthesia, iatrogenic (doctor caused) mishap, all those of hospitalization and an extended convalescent period. The probability of those risks occurring varies with many factors.

• **The risks and dangers attendant to remaining untreated.** Remaining untreated allows the formation of adhesions and reduces mobility which sets up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed. The probability that non-treatment will complicate a later rehabilitation is very high.

**Regarding INSURANCE:** This office will process your insurance forms upon request. We will do our utmost to provide sufficient information to your carrier to obtain payment for your treatment. We have found that, in some instances, insurance companies will deny or reduce payment despite our best efforts to demonstrate the necessity for care. In the event that full payment is not made for any reason, you must understand that you are responsible to make payment in full.

**\*\*\*Do Not Sign Until You Have Read And Understand The Above.\*\*\***

**I have read the above explanation of the chiropractic adjustment and related treatment. Treatment options, risks, and benefits have been discussed, and I have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks and benefits involved in undergoing treatment and have decided to undergo the treatment recommended. Having been informed of all risks and benefits, I hereby give my consent to that treatment.**

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Signature of Parent or Guardian

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Date