revive chiropractic

Last Name:

PEDIATRIC NEW PATIENT FORM

Date: _____

Child's Name:

_____
Last First M.I

Address_____

Sex: _____Male _____ Female Age: _____ Birthdate: _____

Parent/Guardian's Name: _____

Address (if different from above) _____

E-mail (please provide for communication purposes) _____

Cell Phone: _____ Home Phone: _____

Text messaging is our preferred method of communication, is that ok or do you prefer phone? Text____ Phone _____

How did you find out about our clinic? _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Please indicate the main reason(s) your child is seeing us today and age of onset:

_____ _____
_____ _____

Other Treatments previously tried for these conditions: _____

Does this disrupt your child in any of the following areas: play school sleep eating peer interactions
Other:_____
At what frequency: daily weekly monthly

Does affect you and/or your family's home life: daily weekly monthly
Please describe:_____

Please describe any home or school situations that may be causing stress to your child:
_____

Has your child been vaccinated? Yes No On which schedule: Never Routine Extended
Did your child experience any adverse reactions that you noticed after vaccination? Yes No
Please describe:_____

Please describe your child's pregnancy and birth: home birth midwifery center hospital
premature normal gestational age back labor prolonged delivery rapid delivery induced delivery
epidural Pitocin/other stimulants C-Section Vaginal Delivery Suction Forceps Fetal Skull Monitor
Hours in Labor_____
Other Comments: _____

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Hendersonville, TN 37075

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Other Stressful situations during the pregnancy (for you or the family)

_____

Has your child met major developmental milestones for sitting, crawling, standing, and walking? Yes No
If NO, please explain: _____

Does your child appear to interact normally with you and your family? Yes No

_____

How many hours per day does your child do the following:
Play_____ Sit_____ Screen Time (computer/tv/phone,etc)_____
Is your child a "picky eater"? Yes No
What are your child's favorite foods? _____
Allergies: _____

What are 3 things you love about your child or his/her personality:
1)_____ 2) _____ 3)_____

What are 3 of your child's favorite activities or interests:
1)_____ 2) _____ 3)_____

Is there anything that would help your child relax or be more comfortable under our care:

_____

Is there anything that we should avoid while your child is under our care (loud noises, firm touch, fears, etc):

_____

Other important things to know about your child:_____

_____

Financial Responsibility

Natural Healthcare that includes whole food supplementation, exercise and other remedies are not generally covered by third party payers (insurance companies). Revive Chiropractic provides its services directly to you, not to your insurance company. In certain cases, there may be the opportunity for reimbursement. Our financial policy is that fees are paid at the time of service and when products are provided they can be paid for by cash, check, or credit card. However, if applicable, we will provide you with the proper documentation for your reimbursement needs.

I have read and understood all the above information.

_____ _____
Patient Signature Date

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Privacy Practices

We are very concerned with protecting your privacy. While the law requires us to provide you with a complete, detailed disclosure at your request, please understand that we will always respect the privacy of your health information.

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I understand that this organization may need to use my name, address, phone number, e-mail, and clinical records to contact me with appointment reminders, information about treatment alternatives, newsletters, or other health related information that may be of interest to me. I consent to receive communications sent by or on behalf of Revive Chiropractic via regular mail, e-mail, telephone, or fax. If this contact is made by phone and I am not available, a message will be left on my answering machine or with the person answering the phone. By signing this form, I am giving you authorization to contact me with these reminders and information and to leave messages on my answering machine or with individuals at my home or place of employment.

Name _____ Date_____

Acknowledgement of Receipt of Privacy Practices

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

_____

Signature Date

X-Ray Consent

_____Check here if you are pregnant or think you may be pregnant at this time.

I hereby give my consent to Revive Chiropractic and its representatives to take X-rays as deemed appropriate by the examining Doctor of Chiropractic. I also declare that to the best of my knowledge, I am not pregnant.
I have read and understood all the above information.

_____ _____

Patient Signature Date

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Informed Consent to Chiropractic Treatment

The nature of chiropractic treatment: The doctor will use his/her hands or a mechanical device in order to realign your spine. We do many gentle chiropractic techniques, though sometimes you may feel a "click" or "pop" and you may feel movement of the joint. The doctor may request x-rays to be taken if necessary, after reviewing your case. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound or traction may also be used.

Possible risks: As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include muscle soreness, fatigue, fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury, or stroke, could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or other minor complications

Probability of risks occurring: The risks of complications due to chiropractic treatment have been described as "rare", about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury, or stroke, has been estimated at one in one million to one in ten million, and can be even further reduced by screening procedures. We primarily do not use adjustments to the neck region that involve twisting that would cause this type of injury. The probability of adverse reaction due to ancillary procedures is also considered "rare".

Other treatment options that could be considered may include the following:

- *Over-the-counter analgesics.* The risks of these medications include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases.
- *Medical care,* typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.
- *Hospitalization* in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.
- *Surgery* in conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition, and make future rehabilitation more difficult.

Informed Consent and Release of Minor to Chiropractic Treatment

I have read the above explanation of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to allow my child to undergo the recommended treatment, and hereby give my consent to allow my child to be treated.

_____

Parent/Guardian Signature Date

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