Welcome to Slak Chiropractic Group!

Dr. Jean-Marc Slak, DC

Dr. Linda Eisen-Slak, DC

SLAK CHIROPRACTIC
Wellness for the Whole Family

23 Adams Street

Burlington, MA 01803

781-273-0099

PEDIATRIC NEW PATIENT INFORMATION *3-5 Years*

Today's Date: _____ Male ☐ Female ☐

Name: _____ Child's Nickname: _____

Reason for Visit: _____

Date of Birth: _____ Age: _____ Who may we thank for referring you: _____

Home Phone #: _____ Cell Phone #: _____

Child's Home Address:_____

Pediatrician: _____ Office Phone #:_____

Office Address:_____

FAMILY INFORMATION

Parent 1: _____ Parent 2: _____

Home Phone #: _____ Home Phone #: _____

Cell Phone #: _____ Cell Phone #: _____

Parent's Marital Status: Married☐ Single☐ Divorced☐ Widowed☐

Age's of Any Other Children in Family: _____

Predominant Language Used at Home: _____

CONSENT TO TREAT

Being the parent or legal guardian of this child, I hereby authorize this office and its doctors to examine and administer care to my son/daughter named _____ as the examining / treating doctor deems necessary.

I understand and agree that I am responsible for payments of all fees by this office for such care.

Parent's Name: _____ Witnessed by:_____

Signature: X_____ Date:_____

INSURANCE INFORMATION

Does your health insurance cover chiropractic care? Yes ☐ No ☐

If you have insurance that may cover chiropractic services, please provide your current insurance card so that we may make a copy. Additionally, please enter the following information relating to the person who is responsible for the child's health insurance coverage.

Insurance Name: _____ ID#: _____

Subscriber's Name: _____ Date of Birth: _____

Insurance Phone #: _____

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PREGNANCY HISTORY

Today's Date: _____ Child's Name: _____ D.O.B.: _____ Age: _____

Sex: Male ☐ Female ☐ Mother's Name: _____ How many children do you have?: _____

What was the term of your pregnancy?: _____ Weeks How Many Ultrasounds? _____

DURING YOUR PREGNANCY, DID YOU HAVE ANY OF THE FOLLOWING?

	Yes	No	
Falls?	☐	☐	_____
Motor Vehicle Accidents?	☐	☐	_____
Near-Miss MVA?	☐	☐	_____
High Blood Pressure?	☐	☐	_____
Diabetes?	☐	☐	_____
Anemia?	☐	☐	_____
Morning Sickness?	☐	☐	_____
Indigestion?	☐	☐	_____
Seizures?	☐	☐	_____
Swollen Ankles?	☐	☐	_____
Thyroid Problems?	☐	☐	_____
Heart Problems?	☐	☐	_____
Back Pain?	☐	☐	_____
Abnormal Bleeding?	☐	☐	_____
Were you Hospitalized?	☐	☐	_____
Any other Illnesses?	☐	☐	_____
Had Tdap Vaccine?	☐	☐	_____
Had Flu Shot?	☐	☐	_____

DURING YOUR PREGNANCY, DID YOU USE ANY OF THE FOLLOWING?

	Yes	No	
Tobacco?	☐	☐	_____
Alcohol?	☐	☐	_____
Prescription Drugs?	☐	☐	_____
Over-the-Counter Meds?	☐	☐	_____
Recreational Drugs?	☐	☐	_____

How Many Ultrasounds? ____ Any Miscarriages? _____

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BIRTH HISTORY

Today's Date: _____ Child's Name: _____ D.O.B:_____

LABOR AND DELIVERY

How long was the labor from the first regular contractions to the birth? _____hours

How long was the pushing phase of the labor? _____hours

	Yes	No	
Hospital Birth? (Hospital Name)	☐	☐	_____
Home Birth?	☐	☐	_____
Midwife Assisted?	☐	☐	_____
Vaginal Delivery?	☐	☐	_____
Planned C-Section?	☐	☐	_____
Emergency C-Section?	☐	☐	_____
Was Birth Induced?	☐	☐	_____
Forceps Delivery?	☐	☐	_____
Vacuum Extraction?	☐	☐	_____
IV Fluids?	☐	☐	_____
Anesthesia Administered?	☐	☐	_____
Antibiotics?	☐	☐	_____
Fetal Distress?	☐	☐	_____
Meconium Staining?	☐	☐	_____
Cord Wrapped Around Neck?	☐	☐	_____
Head Presentation?	☐	☐	_____
Face Presentation?	☐	☐	_____
Breech Presentation?	☐	☐	_____

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Today's Date: _____ Child's Name: _____ D.O.B:_____

BABY'S CONDITION IMMEDIATELY AFTER BIRTH

Apgar Scores: At 1 Minute: ____/10 At 5 Minutes: ____/10

Baby's Crying: Cried Immediately After Birth ☐ Cried Strongly ☐ Weak Cry ☐ Didn't Cry for ___ Mins

Baby's Color: Pink All Over ☐ Blue Face ☐ Blue Hands/Feet ☐

Baby's Activity: Arms and Legs Actively Moving ☐ Floppy Baby ☐

Intensive Care: Was Required ☐ Days in Neonatal Care Unit ___

Medication Given at Birth? _____ **Vaccines Administered** _____

Birth Weight: _____ lbs./kgs **Birth Length**: _____ins/cms **Baby Home on Day**: _____

DEVELOPMENTAL MILESTONES

✲ Please indicate the ***most complex*** skill that your child can pe rform in each section. ✲
In e ach section, the tasks are arranged in order of increasing developmental age.

GROSS MOTOR SKILLS

☐ Able to hold head up from the table momentarily
☐ Head and shoulder can be supported by the forearms
☐ Infant can be pulled up into a sitting position by the hands

☐ Sits unsupported in the upright position
☐ Head and shoulders supported by the arms
☐ Rolls from prone to supine position
☐ Crawls
☐ Stands holding onto furniture
☐ Walks with someone holding onto one hand

☐ Walks unassisted
☐ Runs
☐ Negotiates stairs placing 2 feet on each step
☐ Climbs stairs using one foot on each step
☐ Walks down stairs with one foot on each step
☐ Hops on one foot

FINE MOTOR SKILLS

☐ Primitive grasp reflex
☐ Holds and shakes a rattle placed in the hand
☐ Grasps objects independently
☐ Moves an object from one hand to the other
☐ Self feeding, can hold and eat a cookie
☐ Checks objects by placing them in the mouth
☐ Picks up object with thumb and index finger
☐ Turns 2 to 3 pages of a book at a time
☐ Turns pages of a book one at a time
☐ Builds a tower containing at least 5 blocks
☐ Builds a tower containing at least 10 blocks

SOCIAL SKILLS

☐ Smiles
☐ Reaches for familiar objects
☐ Plays with hands
☐ Plays with feet
☐ Clearly shows joy and pleasure
☐ Feeds self with fingers
☐ Plays peek-a-boo
☐ Understands yes and no

ADAPTIVE SKILLS

☐ Holds own bottle
☐ Drinks from cup unassisted
☐ Feeds self with utensils
☐ Able to identify and match some colors
☐ Copies a circle
☐ Copies a cross

COMMUNICATION SKILLS

☐ Makes cooing sounds
☐ Laughs
☐ Uses one syllable words such as "da"
☐ Uses 2 syllable words such as "dada"
☐ Uses 2 to 3 word vocabulary
☐ Uses 2 to 3 word phrases

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PRE-SCHOOL CHILD HISTORY ***3-5 YEARS***

Today's Date: _____ Child's Name: _____ D.O.B:_____ Age:_____

	Yes	No	
Does your child complain of pain or discomfort?	☐	☐	_____

If yes, when does this occur?

_____

Was onset sudden or gradual? _____

Problem is constant or intermittent? _____

Has your child ever had this problem before?	☐	☐	_____
Has your child previously been treated for this problem?	☐	☐	By Whom: _____
Has your child previously had chiropractic care?	☐	☐	By Whom: _____

HEALTH HISTORY

Does your child ever complain of back or neck pain?	☐	☐	_____
Does your child ever complain of pains in the legs or arms?	☐	☐	_____
Does your child ever complain of headaches?	☐	☐	_____
Has your child had asthma?	☐	☐	_____
Is your child allergic to anything?	☐	☐	_____
Are there any smokers in the child's home?	☐	☐	_____
Has your child had any earaches? (At what age did 1st occur?)	☐	☐	_____
How frequently does your child have earaches?			_____
Right? Left? Both?			_____
Is your child presently taking any prescribed medication?	☐	☐	_____

Please list any other illnesses which have been a concern for your child: _____

_____

_____

Please list any surgeries your child has had: _____

_____

_____

For office use: Scan _____

Today's Date: _____ Child's Name: _____ D.O.B:_____ Age:_____

TRAUMA

	Yes	No	
Has your child had any recent falls or trauma?	☐	☐	_____
Describe the trauma and the date it occurred	_____		
Has your child ever fallen down the stairs or fallen from any height?	☐	☐	_____
Has your child ever been in a motor vehicle collision or near miss?	☐	☐	_____
Has your child ever had a bone fracture or joint dislocation?	☐	☐	_____
Has your child had any other trauma or injuries?	☐	☐	_____
Does your child ever bang their head repeatedly against a wall, bed or other object?	☐	☐	_____

NUTRITION

	Yes	No	
Do you have any concerns about your child's diet?	☐	☐	_____
Does your child have any food allergies?	☐	☐	_____
Does your child take vitamin supplements?	☐	☐	_____
Does your child eliminate stools each day?	☐	☐	_____
Does your child have any persistent or intermittently occurring skin rashes?	☐	☐	_____
For how many months was your child breast fed?			_____
What does your child usually eat for Breakfast?	_____		
What does your child usually eat for Lunch?	_____		
What does your child usually eat for Dinner?	_____		
What does your child usually eat for Snacks?	_____		
How much cow's milk does your child drink each day?	_____		
What is your child's favorite food?	_____		
What type of fast foods does your child like to eat?	_____		

Do you have any other concerns about your child's health?_____

_____

_____

_____

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INFORMED CONSENT

Slak Chiropractic Group

Patient Name Printed: X_____ File #: _____

Chiropractic is the science of locating, and removing interference with the transmission or expression of nerve force in the human body, by the correction of misalignments or subluxations of the bony articulations and adjacent structures more especially those of the vertebra column and pelvis, for the purpose of restoring and maintaining health. Chiropractic recognizes that essentially only the body heals and, therefore, holds forth no cure for disease and does not guarantee any specific result. The primary chiropractic examination finding is the Vertebral Subluxation and the primary chiropractic procedure is the chiropractic adjustment, performed manually and/or with a manual device.

The material risks inherent in the chiropractic adjustment and examination: There are potential complications with any health care procedure. The most common side effect is stiffness and soreness and moving of symptoms during the first few weeks of care. Bruising can occur. Rare complications include fractures, disc injuries, dislocations, paralysis, strains and sprains. Some techniques used to manipulate the cervical spine (neck region) have been implicated in injury to the arteries in the neck leading to, or contributing to, serious complications that includes stroke. One prominent authority states that there is, at most, a one-in-a-million chance of such an outcome.

Ancillary procedures and additional risks: Ancillary procedures sometimes used include light, vibration, massage, and therapeutic exercise. Vibration, massage, and exercise have risks similar to Chiropractic Adjustments; and vigorous exercise may pose a significant health risk to those with advanced cardiovascular disease.

Availability and nature of treatment options: Other treatment options include self-administered over-the-counter analgesics, rest, prescription drugs, hospitalization, surgery and rehabilitation. The material risks inherent in such options and the probability of such risks occurring are significant. Chiropractors may provide general information, but they do not provide medical advice. We strongly suggest that you consult a knowledgeable physician when making a decision to take or discontinue medications.

The risks and dangers attendant to remaining untreated: Remaining untreated may promote the formation of adhesions and reduction of mobility. A pain reaction may result that further reduces 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 later complicate rehabilitation is relatively high.

Payment for services: Co-pays, deductibles and cash balances are due before service is rendered. This is to keep you informed of charges before they are incurred and to provide faster service. Any over-payment is refunded.

X-RAYS

X_____ (patient initials) Recommended x-rays may be taken at any facility of your choosing.

- X-ray films are kept as part of your permanent medical record. Copies are available in digital format. Please allow 5-10 business days after written request.

Flare-ups and injuries: It is your responsibility to tell the treating chiropractor if you've had a flare-up or new injury, before he/she starts treating you.

CONSENT

I have read or have had read to me the above explanation of the chiropractic examination, adjustment and related treatment. I have discussed any questions I have with the attending chiropractor and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks and benefits of treatment and have decided that it is in my best interest to undergo the treatment recommended and give my consent to the aforementioned examination and treatment.

X_____	_____	X_____	_____
Signature (guardian if a minor)	relationship of guardian to patient	Date	Witness

Rev 8-28-18

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PRIVACY NOTICE ACKNOWLEDGEMENT

We are very concerned with protecting your privacy, especially in matters that concern your personal health information. In accordance with the *Health Insurance Portability and Accountability Act* of 1996 (HIPAA), we are required to provide you with a copy of our privacy policies and procedures. We encourage you to read this document carefully for it outlines the use and limitations of the disclosure of your health information and your rights as a patient. If you ever have any questions or concerns regarding the use or the dissemination of your personal health information, we would be happy to address them.

I acknowledge that I have received a copy of the Slak Chiropractic Group *Notice of Privacy for Health Information.*

X _____
Patient Name Printed

X _____
Date

X _____
Patient Signature

_____
Authorized Provider Representative

_____
Parent Name Printed (for minors)

_____
Parent Signature (for minors)

I authorize Slak Chiropractic group and their representatives to contact me by phone and email.
I authorize Slak Chiropractic Group to release any information to obtain payment for my services and to receive direct third party payment for my services.
I authorize Dr. Slak to send a thank you note to the person who referred me to this office in order to acknowledge their thoughtfulness.

X _____
Patient Signature

SLAK CHIROPRACTIC
Wellness for the Whole Family

Non-Covered Service Waiver Form

For the Patient

I understand that I am responsible for all costs associated with chiropractic care, ancillary services, maintenance and wellness visits. This notice informs me that my insurance company may not pay for certain services including some supportive therapies, maintenance and wellness visits because my insurance company does not consider them covered services or medically necessary.

Member Name: X_____

Member ID Number: _____

Member Signature: X _____ Date: X _____

For the provider

I verify that I have informed my patient _____ that their insurance company does not allow payment for certain supportive therapies, maintenance and wellness visits because they do not consider them covered services or medically necessary.

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