Welcome to Slak Chiropractic Group!

Dr. Jean-Marc Slak, DC

Dr. Linda Eisen-Slak, DC

23 Adams Street

Burlington, MA 01803

781-273-0099

PEDIATRIC NEW PATIENT INFORMATION *6 YEARS & UP*

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 #: _____

Scanned:____

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? _____

Scanned:____

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 Name)
Hospital Birth?	☐	☐	_____
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?	☐	☐	_____

Scanned:____

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

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**: _____

SCHOOL-AGE CHILD *6 YEARS & UP*

ABOUT YOUR LIFESTYLE

What grade are you in at school?_____

How do you carry your school books? _____

How heavy is your school book bag? _____

What sports do you play? _____

What hobbies do you have? _____

_____

How many hours of TV do you watch? _____

How many hours do you spend on the computer each day? _____

How often do you play video games? (how many hours?) _____

On average, how many hours of sleep do you get each night? _____

Are there any smokers in your family? _____

Do you feel stressed out? _____

Do you have trouble reading the board in class? _____

Do you ever have blurred vision? _____

Do you wear contact lenses? _____

Do you sometimes get headaches when you read? _____

Scanned:____

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

SCHOOL-AGE CHILD ***6 YEARS & UP***

ABOUT YOUR DIET

What do you usually eat for Breakfast? _____

What do you usually eat for Lunch? _____

What do you usually eat for Dinner? _____

What snacks do you have after school? _____

What is your favorite food? _____

How much water do you drink each day? _____

How much soda or sugary drinks do you drink each day? _____

How often do you eat fast food? _____

Reason for Today's Visit:_____

_____

When did this problem first occur? _____

_____

	Yes	No	
Has your child ever had this problem before?	☐	☐	_____
Has your child been treated for the problem?	☐	☐	_____

Doctor's Name: _____

Has your child previously been to a chiropractor? ☐ ☐ _____

(When and by Whom?) Chiropractor's Name: _____

Back or Neck Pain?	☐	☐	_____
Pains in the legs or arms?	☐	☐	_____
Headaches?	☐	☐	_____
Asthma?	☐	☐	_____
Allergies?	☐	☐	_____
Earaches?	☐	☐	_____
Falls from a bicycle, scooter, rollerblades or similar?	☐	☐	_____
A problem with bedwetting?	☐	☐	_____
Ever been in a motor vehicle accident?	☐	☐	_____
Ever had any surgeries?	☐	☐	_____
Is your child taking any medications?	☐	☐	_____
Does your child have any other health problems?	☐	☐	_____

_____

Scanned:____

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

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.

Dr. Linda Eisen-Slak
Dr. Jean-Marc Slak
23 Adams Street
Burlington, MA 01803
(781) 273-0099

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 _____ X _____
Patient Name Printed 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