Welcome to Slak Chiropractic Group!

Dr. Jean-Marc Slak, DC

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SLAK CHIROPRACTIC
Wellness for the Whole Family

23 Adams Street

Burlington, MA 01803

781-273-0099

PEDIATRIC NEW PATIENT INFORMATION *2 MONTHS TO 2 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? Y / N

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: _____ Sex: M / F D.O.B.: _____ Age: _____

Mother's Name: _____ How many children do you have?: _____

What was the term of your pregnancy?: _____ Weeks

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? Flu?	☐	☐	_____
COVID Vaccine?	☐	☐	_____

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?	☐	☐	_____

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**: _____

NEWBORN HISTORY *BIRTH TO 2 MONTHS*

The following questions are designed to help the doctor provide the best possible spinal care for your child.

How many hours does your baby sleep between feeds? During Day: _____ At Night: _____

	Yes	No	
Does your baby go to sleep easily?	☐	☐	_____
Does baby have a preferred sleeping position?	☐	☐	_____
Does baby cry if you change the sleeping position?	☐	☐	_____
Does baby have any feeding difficulties?	☐	☐	_____
Is baby being breastfed? (If no, for how long?)	☐	☐	_____
Does baby have a one-sided breastfeeding preference?	☐	☐	_____
Is baby formula fed? (Which formula or milk source?)	☐	☐	_____
Does baby frequently spit-up after feeding?	☐	☐	_____
Does baby cry a lot? (For how many hours each day?)	☐	☐	_____
Does baby pass a lot of intestinal gas?	☐	☐	_____
Does baby have a preferred head position?	☐	☐	_____
Does baby frequently arch their head & neck backwards?	☐	☐	_____
Does baby cry or become irritable during diaper change?	☐	☐	_____
Has baby ever had a fever?	☐	☐	_____
Has baby had any falls?	☐	☐	_____
Has baby had any other trauma?	☐	☐	_____
Has your baby been vaccinated?	☐	☐	_____

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DEVELOPMENTAL MILESTONES

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

✲ Please indicate the only the ***most complex*** skill that your child can perform in each section. (should be 1 per section)✲

In each 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

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

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

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

ADAPTIVE SKILLS

___Holds own bottle
___Feeds from cup unassisted
___Feeds self with utensils
___Able to identify and match some colors
___Copies a circle
___Copies a cross

INFANT HISTORY ***2 MONTHS TO 2 YEARS***

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

The following questions are designed to help the doctor provide a detailed evaluation of your child.

NUTRITION

	Yes	No	
Is your child still being breastfed? If no, for how long?	☐	☐	_____
If yes, how much cow's milk does the mother consume each day?	☐	☐	_____
Is your child formula fed? Which formula or other milk source?	☐	☐	_____
Is your child eating solid foods? (Which foods)	☐	☐	_____
What is your child's favorite food?	☐	☐	_____
Does your child have any feeding difficulties?	☐	☐	_____
Does your child have and digestive disturbances?	☐	☐	_____
Does your child have any food allergies?	☐	☐	_____
Does your child have any persistent or intermittent skin rashes?	☐	☐	_____
Is your child receiving and vitamin supplements?	☐	☐	_____

TRAUMA

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?	☐	☐	_____

INFANT HISTORY ***2 MONTHS TO 2 YEARS***

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

GROWTH & DEVELOPMENT

	Yes	No	
Can your child sit unsupported?	☐	☐	_____
Is your child crawling yet? (at what age did they start?)	☐	☐	_____
Is your child walking yet? (at what age did they start?)	☐	☐	_____
Does your child often trip and fall?	☐	☐	_____

Do you have any concerns about your child's growth and development?_____

_____

_____

HEALTH HISTORY

Has your child had colic?	☐	☐	_____
Has your child had any upper respiratory infections? (How often?)	☐	☐	_____
Has your child had asthma?	☐	☐	_____
Does your child ever complain of back or neck pain?	☐	☐	_____
Does your child ever complain of pains in the arms or legs?	☐	☐	_____
Does your child ever complain of headaches?	☐	☐	_____
Has your child had any earaches? (At what age did 1st occur?)	☐	☐	_____
How frequently does your child have earaches?	☐	☐	_____
Do the earaches usually tend to occur in the same ear?	☐	☐	_____
Right, Left or Both?			
Has your child had any other illnesses?	☐	☐	_____
Please list each illness and its approximate date			
Is your child presently receiving any medications?	☐	☐	_____
Has your child recently been vaccinated?	☐	☐	_____
Has your child ever been to a hospital			
or ER for evaluation or treatment?	☐	☐	_____

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

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

SLAK CHIROPRACTIC

Wellness for the Whole Family

AUTHORIZATION: The process of determining suitability for Chiropractic Services involves answering fully and truthfully all questions presented to either written or spoken regarding your past and present health status. If warranted, a physical examination will be performed that can include but is not limited to vitals measurement, systems evaluation, orthopedic tests, and maneuvers (tests that move and stress parts of the body), neurological test (tests using sharp or dull instruments, smells, or sounds, gently tapping) as well as physical touching. These tests and maneuvers will help the Chiropractor determine what may be causing your complaints. Occasionally some temporary soreness and/or stiffness may occur due to the examination, less frequently aggravation of presenting symptoms or initiation of new symptoms. By signing below, you have authorized the performance of a consultation and examination.

ACKNOWLEDGEMENT: We are very concerned with protecting your personnel health information. There may be times our office may need to contact you regarding office matters. By signing below, you have authorized this office to contact you for office related matters and thank you notices for referrals using your first name in the following manner: phone-work-home or mobile, e-mail and regular mail to include sealed envelopes and postcards. Messages may be left on an answering device/voicemail, or with the person answering your phone-home-work mobile. Also, in accordance with the Health Insurance Portability and Accountability act of 1996 (HIPAA), updated September 23, 2013, this office is obliging to supply you with a copy of the office privacy policies and procedures upon request. This document outlines the use and limitations of the disclosure of your personal health information and your rights as a patient.

I ACKNOWLEDGE THAT I HAVE BEEN OFFERED A COPY OF:
NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION.

Patient Name Printed	Date
Patient Signature	Authorized Provider Rep.
Personal Representative Printed	Personal Rep. Signature