TEAM CHIROPRACTIC & Sports Medicine, P.A.

PEDIATRIC CONSULTATION

(8-12 years old)

Patient information

Child's Name _____ Sex: Male / Female
Child's Birthday: _____
Parent or Legal Guardian Name _____
Address: _____
City, State, Zip: _____ Home Phone:_____
Where do prefer to receive calls? _____ Work Phone: _____
Person to contact in case of emergency? _____ Phone: _____
Pediatrician? _____ Phone: _____

Responsible Party

Name of person responsible for this account: _____
Address: _____ Home Phone: _____
City, State, Zip: _____ Work Phone: _____
Relationship to patient: _____

Any complications with birth? _____

C-Section? Yes No

Was there any pulling on the head? Yes No Any vacuum extraction? Yes No

Has your child been immunized? Yes No Any reactions? Yes No

Explain any reactions: _____

When was the child's most recent fall? _____

Was any care given? _____ Was s/he checked by a chiropractor? _____

And the fall before that? _____ Any care given? _____

What sports or recreational activities does he/she do? _____

When was the child's most recent stress, strain, or injury while doing these activities?
_____

Care given? _____

Has the child been involved in a motor vehicle accident as a passenger? Yes No

Briefly describe: _____

Any treatment received? _____ Chiropractic? _____

Does your child have any health concerns? _____

If so, for how long? _____

Are there any other conditions/illness that your child is or was experiencing?
_____

How long? _____

Depending on the type and degree of the subluxated vertebra, the nerve pressure can be constant or occasional. How often does your child have this condition? _____

Any medications? _____

Is there anything else that you feel is important that has not been addressed on this form?

Authorization
I the undersigned have read and answered the above information to the best of my knowledge. The above questions have been accurately answered on behalf of my child. I understand that providing incorrect information can be dangerous to my child's health. I authorize the chiropractor to release any information including the diagnosis and the records of any treatment or examinations rendered to my child during the period of such said chiropractic care to third party payers and/or health practitioners. Providing my insurance provides for the care of my child, I authorize and request my insurance company to pay directly to the chiropractor or chiropractic group insurance benefits otherwise payable to me. I understand, provided my insurance is accepted and provides for my child, that the carrier may pay less than the actual bill for the services. I agree to be responsible for payment of all services rendered on behalf of my dependents.

Signature of parent or legal guardian **Date**

ORIENTATION & INFORMED CONSENT TO CHIROPRACTIC TREATMENT

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective. It is important that each patient understand both the objective and the method that will be used to attain our goal. This will prevent any confusion or disappointment. **Chiropractic has only one goal: to eliminate misalignments within the spinal column, which interfere with the expression of the body's innate wisdom.** We do not offer to diagnose or treat any disease or condition other than vertebral subluxation.

Allow us to introduce some terms you need to be familiar with as you receive your chiropractic care:

- **Adjustment:** the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is specific adjustments of the spine and extremities. **Dr. Lawrence D. Dodd and his associates** will use his/her hands or a mechanical device in order to move your joints. You may feel a "click" or "pop." Cold packs, diet, nutritional supplementation, exercises, traction or any other treatments may also be used.
- **Health:** a state of optimal physical, mental, and social well being, not merely the absence of disease or infirmity.
- **Vertebral Subluxation:** a misalignment of one or more of the 24 vertebrae in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

Possible Risks: As with any health care procedure, complications are possible following a chiropractic manipulation, Power Plate Vibration Therapy or exercises. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. A minority of patients may notice stiffness or soreness after the first few days of treatment. Cerebrovascular injury or stroke leading to death could occur upon severe injury to arteries of the neck. Nutritional supplementation we recommend may cause energy or chemical imbalances causing injury or death.

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 twenty million, and may be even further reduced by screening procedures.

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.

I, _____, have read and fully understand the above statements. I have also 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 undergo the recommended treatment plan, and herby give my full consent for chiropractic care.

_____ _____

Signature *Date*

I hereby grant permission to Team Chiropractic to perform any necessary tests on my minor child, and to render care for said child. I acknowledge that I am the parent or legal guardian of the child listed on this form.

Signature of Parent or Legal guardian Date

Patient Consent HIPAA

I, _____, hereby consent to Team Chiropractic permission to call my □ home, □ cell, and □ work number for appointment reminders and routine office needs regarding my account.

I hereby consent for Team Chiropractic to leave any messages for appointments, changes in schedule, and routine office needs with the following family members:

_____ Relation:_____

_____ Relation:_____

I hereby revoke any information to be given to the following family members regarding any routine office needs here at Team Chiropractic:

_____ Relation:_____

_____ Relation:_____

Due to the privacy act created by the Centers for Medicare and Medicaid, this office is required to have your signature allowing us to treat you. If you would like to have the details pertaining to the Health Information Portability and Accountability Act (HIPAA), please ask the receptionist for the Notice of Privacy Practices.

"I have read and understand the notice of privacy practices and hereby give my consent to this office to attend to me according to the usual and customary practices contained therein."

_____ _____

Patient Name, printed Patient Signature

_____

Date

An informed consent to X-Ray

Team Chiropractic & Sports Medicine
309 W. Millbrook Dr. #199
Raleigh, NC 27609.
(919) 788-8881

I _____ hereby allow the doctors, assistants, or designated staff of *Team Chiropractic and Sports Medicine* to perform any x-ray procedures necessary. I understand that these procedures are useful in helping to determine the cause of my problem. They may also be used for subsequent re-evaluations to determine my progress throughout my treatment program.

My understanding is that the actual x-ray film is the property of Team *Chiropractic and Sports Medicine*; however, the information on the film is mine. I am able to obtain a copy of these films at an additional charge to pay for the physical film itself.

Team Chiropractic and Sports Medicine does allow a patient to borrow their x-ray films for a maximum of thirty (30) days in order to coordinate care with other health care professionals. This requires a signed release from the health professional and has a strict 30 day return policy. *Team Chiropractic and Sports Medicine* is held legally liable to have original copies of all x-rays taken at this clinic for a minimum of seven (7) years.

I understand that if I am pregnant and have X-rays taken which expose my lower torso to radiation there is a risk that my fetus may be injured.

I have been advised that the 10 days following the onset of a menstrual period are generally considered to be safe for X-ray examinations.

With those factors in mind, I am advising my doctor that:

	Yes	No	Don't Know
I am pregnant	___	___	____
I could be pregnant	___	___	____
I am late with my menstrual period	___	___	____
I am taking oral contraceptives	___	___	____
I have an IUD	___	___	____
I have had a tubal ligation	___	___	____
I have had a hysterectomy	___	___	____
I have irregular menstrual periods	___	___	____

My last menstrual period began on: _____

An X-Ray may be performed on me with my consent.

Patient: Signature_____ Date_____

Print_____

Witness: Signature _____ Date_____

Print _____

Family/Non-Family Release Consent

I, _____, hereby consent to release my child's medical records and files to the following family or non-family members:

Name: **Relationship:**

Reason:

Signature of parent/legal guardian: **Date:**

Witness: Date: