New Wave CHIROPRACTIC

# New Practice Member Pediatric Application

Child's Name: _____ Date of Birth: ____/____/____ Age: _____

Gender: M / F Weight _____ lbs. Height: _____ ft. _____ in.

## Parent/Guardian Information

Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone Number: _____ Email: _____

Occupation: _____ Employer: _____

Who may we thank for referring you? _____

Reason for pursuing care: ☐ Maintenance ☐ Improved Health ☐ Health Issue

## Insurance Information

*(Please give your insurance card and driver's license to the front desk for a complimentary insurance benefits check)*

Primary Insurance Carrier: _____ Subscriber's Name: _____

Occupation: _____ Employer: _____ Date of Birth: ____/____/____

## List The Heath Concerns That Brought You Into This Office

| Health Concerns List According To Severity ↓ | Rate of Severity 0 = No Pain 10 = Unbearable | When Did This Problem Start? | Have You Had the Problem Before? If So, When? | Did The Problem Begin With an Injury? | Are Symptoms Constant (C) Or Intermittent (I)? |
|---|---|---|---|---|---|
| **Primary:** _____ | _____ | _____ | _____ | _____ | _____ |
| **Second:** _____ | _____ | _____ | _____ | _____ | _____ |
| **Third:** _____ | _____ | _____ | _____ | _____ | _____ |
| **Fourth:** _____ | _____ | _____ | _____ | _____ | _____ |

## Release of Authorization/ Assignment of Benefits

I authorize the release of any information necessary to process my insurance claims. I authorize and request payment of insurance benefits directly to the doctors. I agree that this authorization will cover all services rendered until I revoke the authorization. I agree that a photocopy of this form may be used in place of the original. All professional services rendered are charged to the patient. It is customary to pay for services when rendered unless other arrangements have been made in advance. I understand that I am financially responsible for charges not covered by my insurance.

Parent/Guardian Signature: _____ Date: _____



***"The Power that Made the Body Heals the Body." -B.J. Palmer***

Patient Name: _____ HR #: _____ Date: ____ /____ /____

## Please Mark "**P**" for in the Past OR Mark "**C**" for Currently Have:

| | | | | |
|---|---|---|---|---|
| ___ Allergies | ___ Ear Infection | ___ Colic | ___ Seizures | ___ Autism |
| ___ Hearing Loss | ___ Frequent Colds | ___ Constipation | ___ Sleep Problems | ___ Digestive Problems |
| ___ Back Pain | ___ Asthma | ___ ADD/ADHD | ___ Bed Wetting | ___ Tight/ Sore Muscles |
| ___ Headaches | ___ Recurring Fevers | ___ Temper Tantrums | ___ Scoliosis | ___ Sports Injury |

Other: _____

## Please Mark "**P**" for in the Past OR Mark "**C**" for Currently Have:

____ CANCER ____ SPINAL SURGERY ____ SEIZURES ____ SPINAL BONE FRACTURE ____ SCOLIOSIS ____ DIABETES

LIST ALL SURGICAL OPERATIONS AND YEARS: _____

LIST ANY OTHER INJURIES TO YOUR SPINE, MINOR OR MAJOR, THAT THE DOCTOR SHOULD KNOW ABOUT:

_____

WHEN WAS YOUR LAST AUTO ACCIDENT? _____

HAVE YOU EVER BEEN KNOCKED UNCONSIOUS? YES / NO FRACTURED A BONE? YES / NO

IF YES TO EITHER OF THE ABOVE, PLEASE DISCRIBE: _____

OTHER TRAUMA: _____

_____

HAVE YOU HAD PREVIOUS CHIROPRACTIC CARE? YES / NO

IF YES, DR. & DATE: _____

PRESCRIPTION DRUGS/DOSAGE: _____

OVER THE COUNTER DRUGS (Tylenol, Cough Syrup, Laxatives, etc.): _____

## PREGNANCY & BIRTH HISTORY

Name of Obstetrician/Midwife: _____

# Ultrasounds During Pregnancy: _____

Medications, Cigarettes, or Alcohol During Pregnancy? Yes / No, If YES, Explain: _____

Complications During Pregnancy/Delivery? Yes / No, If YES, explain: _____

Birth Location (circle one): Hospital Birth Center Home

Birth Intervention (circle all that apply): Forceps Vacuum Extraction Epidural Induction of Labor C-Section



*"There is a Vast Difference between Treating Effects and Adjusting the Cause." -D.D. Palmer*

Patient Name: _____ HR #: _____ Date: ____ /____ /____

## FEEDING HISTORY

Breast Fed: Yes / No How long? _____ Formula Fed: Yes / No How Long? _____ Type: _____

Introduction to: Solid Food @ _____ months Cow's Milk @ _____ months

Food/Juice Allergies or Intolerance: Yes / No List: _____

## DEVELOPMENTAL HISTORY

Your child's spine is most vulnerable to stress and should routinely be checked by a Doctor of Chiropractic for prevention and early detection of vertebral subluxations that lead to spinal nerve interference.

At what age was your child able to:

Respond to Noise Stimuli _____ Crawl _____ Stand Alone _____ Roll _____

Respond to Visual Stimuli _____ Hold Head Up _____ Walk Alone _____ Sit Up _____

**According to the National Safety Council, approximately 50% of children fall head first from a high place during their first year of life.** (i.e. from a bed, changing table, down the stairs)

Has your child had a fall similar to what was described above? Yes / No Explain: _____

Has your child had an emergency doctor visit? Yes / No Explain: _____

Other traumas not described above? _____

## LIFESTYLE

Does your child (circle all that apply): Eat Healthy Foods Drink Water Take Vitamins Take Probiotics

Exercise (circle one): None Moderate Daily Heavy

Hobbies/Interests: _____

Has your child been involved in any sports? Yes / No List: _____

Is there anything else you would like to tell us about your child? _____

_____

# Quadruple Visual Analogue Scale (QVAS)

Please circle the number that best describes the question asked. If you have more than one complaint, please answer for each individual complaint and indicate the score for each complaint.

EXAMPLE

No Pain — Worst Possible Pain

0 1 2 3 4 5 6 7 8 9 10

1. How would you rate your pain right now?

0 1 2 3 4 5 6 7 8 9 10

2. What is your typical AVERAGE pain?

0 1 2 3 4 5 6 7 8 9 10

3. What is your pain level at its BEST? (how close to 0 does your pain get at its best)

0 1 2 3 4 5 6 7 8 9 10

What percentage of your awake hours is your pain at its best? _____%

4. What is your pain level at its WORST? (how close to 10 does your pain get at its worst)

0 1 2 3 4 5 6 7 8 9 10

What percentage of your awake hours is your pain at its worst? _____%

Practice Member Name: _____ Date: _____

Score: Q1_____ + Q2_____ + Q4_____ = _____ / 3x10 = _____ (low intensity = <50; high intensity >50)

Patient Name: _____ HR #: _____ Date: ____ /____ /____

# Family Health History

This form is to assist the doctors by providing past health history information for their review. Please mark with an "X" if any of the following applies to your family.

| Condition | Mother | Father | Brother | Sister |
|---|---|---|---|---|
| Headaches | | | | |
| Neck Pain | | | | |
| Jaw/TMJ Pain | | | | |
| Dizziness | | | | |
| Hearing Loss | | | | |
| Blurred/Double Vision | | | | |
| Allergies | | | | |
| Sinus Issues | | | | |
| Loss of Energy | | | | |
| Anxiety | | | | |
| Depression | | | | |
| Thyroid Problems | | | | |
| Shoulder Pain | | | | |
| Back Pain | | | | |
| Hip/Leg Pain | | | | |
| Sciatica | | | | |
| Arthritis/Joint Pain | | | | |
| Asthma | | | | |
| Breathing Problems | | | | |
| Heart Problems | | | | |
| High Blood Pressure | | | | |
| Stomach Problems | | | | |
| Bed Wetting | | | | |
| Infertility | | | | |
| Fibromyalgia | | | | |
| Poor Posture | | | | |
| Sleep Problems | | | | |
| Stroke | | | | |
| Cancer | | | | |
| Heart disease | | | | |
| Diabetes | | | | |
| Alzheimer's | | | | |

# Informed Consent for Chiropractic Care

Chiropractic care, like all forms of health care, while offering considerable benefits may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases, injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include: sprain/strain of muscles, irritation of a disc condition, and rarely, rib fractures. One of the rarest complications associated with chiropractic care occurring at a rate between one instance per one million to one instance per two million cervical spine (neck) twisting adjustments may be a vertebral injury that could lead to a stroke.

Prior to receiving chiropractic care in the Chiropractic office, a health history and physical examination will be completed. These procedures are performed to assess your specific conditions, your overall health, and in particular your spinal health. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies are needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another healthcare provider. All relevant findings will be reported to you along with a care plan prior to beginning care.

- I understand and accept that there are risks associated with chiropractic care and give consent to the examination that the doctor deems necessary and the chiropractic care, including spinal adjustments, as reported following my assessment.

- I agree that a photocopy of this form may be used in place of the original. All professional services rendered are charged to the practice member. It is customary to pay for services when rendered unless other arrangements have been made in advance. I understand that I am financially responsible for charges not covered by this assignment.

## Name of practice member who is a child/minor: _____

I authorize Dr. MacKenzie Ryczek, Dr. Nick Ryczek, and any and all New Wave Chiropractic team members to perform diagnostic procedures, radiographic evaluations, render chiropractic care and perform chiropractic adjustments to my child/minor. As of this date, I have the legal right to select and authorize healthcare services for my child/minor. If my authority to select and authorize care is revoked or altered, I will immediately notify New Wave Chiropractic.

Guardian Signature: _____ Date: _____

Relationship to Minor: _____

# Terms of Acceptance

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.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

**ADJUSTMENT:** An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxations. Our chiropractic method of correction is by specific adjustments to the spine.

**HEALTH:** A state of optimal physical, mental, and social well-being, not merely the absence of disease or illness.

**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.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxations. However, if during the course of chiropractic spinal examination, we encounter non-chiropractic or unusual finding, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of another healthcare provider.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method of practice is delivering specific chiropractic adjustments to correct vertebral subluxations.

I, _____ have read and fully understand the above statements.
All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis.

Parent/Guardian Signature: _____ Date: _____

# Notice of Privacy Practices Acknowledgment

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

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

I acknowledge that I may request your NOTICE OF PRIVACY PRACTICES containing a more complete description of the uses and disclosures of my health information. I also understand that I may request, in writing, that you restrict how my private information is used to disclose to carry out treatment, payment, or healthcare operation. I also understand you are not required to agree to my requested restrictions, but if you agree, then you are bound to abide by such restrictions.

Parent/Guardian Signature: _____ Date: _____

# X-Ray Authorization

As your healthcare provider, we are legally responsible for your chiropractic records. We must maintain a record of your x-rays in our files. At your request, we will provide you with a copy of your x-rays in our files. The fee for copying your x-rays onto a disc is $10. This fee must be paid in advance. Digital x-rays on a CD will be available within 72 hours of prepayment on any regular practice day of operation. Please Note**:** X-rays are utilized in this office to help locate and analyze vertebral subluxations. The doctors of New Wave Chiropractic do not diagnose or treat medical conditions; however, if any abnormalities are found, we will bring it to your attention so that you can seek proper medical treatment.

By signing below, you are agreeing to the above terms and conditions.

Name of practice member who is a child/minor: _____ DOB: _____

Parent/Guardian Name: _____

Parent/Guardian Signature: _____ Date: _____

# Photo Release

I grant New Wave Chiropractic and its employees the right to take photographs of me with connection to the promotion of chiropractic via website, social media, and any other avenue. I agree that New Wave Chiropractic may use such photographs of me and for any lawful purpose, including such purposes as publicity, illustration, advertising, and web content.

If under 18 years of age, the legal guardian or parent has read and understands the above:

Parent/Guardian Signature: _____

Doctor Signature: _____ Date: _____