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REBELUTION HEALTHCARE

PEDIATRIC INTAKE PAPERWORK

HELLO AND WELCOME TO THE REBELUTION!

Who may we thank for referring you / how did you hear about us? _____

Has your child received chiropractic care in the past? ❑ No ❑ Yes, as an ❑ Infant ❑ Child ❑ Teen

From whom did your child receive chiropractic care? _____ ❑ N/A

Please fill out the following information completely and to the best of your ability.
Remember to initial the bottom of each page.

PERSONAL INFORMATION

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

Child's Preferred Name: _____ Gender: ❑ Male ❑ Female

Email: _____ Marital Status: ❑ S ❑ M ❑ D ❑ W

Street Address: _____ City/State/Zip: _____

Guardian #1: _____ Relationship to Child: _____

Phone (❑Cell ❑Home ❑Work) _____ Email: _____

Guardian #2: _____ Relationship to Child: _____

Phone (❑Cell ❑Home ❑Work) _____ Email: _____

Who is responsible for the child's finances?
❑ Guardian #1 ❑ Guardian #2 ❑ Both

What is the relationship between #1 and #2?
❑ Married ❑ Divorced ❑ Other: _____

Siblings (Name(s)/Age(s)): _____ Child's Hobbies: _____

PRENATAL, BIRTH, & INFANCY HISTORY

If your child is above the age of 5, skip to PERSONAL HEALTH HISTORY

Birth Weight: ___lb ___oz Height: ___in At how many weeks of pregnancy was your child born? _____

Name of ❑ Doctor/ ❑ Midwife: _____ Delivery method: ❑ Vaginal ❑ C-Section ❑ VBAC

List any drugs/medications that you took during pregnancy: ❑ N/A _____

List any complications, serious illness, or health emergency that the mother experienced during the birth or pregnancy: ❑ N/A _____

PERSONAL & PAST HEALTH HISTORY

Current Weight: _____ lbs Height: ____ ft ____ in

Has your child received vaccines? ❑ No ❑ Yes
if yes ❑ On regular schedule ❑ delayed schedule

Is your child exposed to secondhand smoke?
❑ Never ❑ In the Past ❑ Occasionally ❑ Daily

Indicate if your child has experienced the following:
❑ N/A ❑ Been unconscious due to illness or injury
❑ Serious illnesses, operation, or health emergency
❑ Motor vehicle accident ❑ Fractured a bone
Explain (include year(s)): _____

List over-the-counter/prescription drugs that your child is currently taking: ❑ N/A _____

Does your child have any genetic disorders or disabilities? ❑ No ❑ Yes (*If yes, explain*): _____

Has your child's symptom/pain/reason for seeking chiropractic care happened BEFORE? ❑ No ❑ Yes
What treatment did you seek? ❑ N/A How were your results? ❑ Good ❑ Poor

Help us identify past conditions or procedures that could be *related to your child's main issue*:
❑ N/A ❑ Past surgeries ❑ Childhood diseases ❑ Past injuries *Explain:* _____

INITIALS ____

CHIEF COMPLAINT / HISTORY OF PRESENTING ILLNESS

Name: _____ Date: _____

What is the MAIN symptom/pain/reason you are seeking chiropractic care for your child?

PROBLEM/CONCERN #1: _____

- Rate your child's CURRENT pain/discomfort: ___ /10 WHEN did the problem begin? _____
- Did your child do something/did something happen that caused/aggravated the problem?
  ❑ No ❑ Yes *If yes, explain:* _____
- Does the problem RADIATE outward? ❑ No ❑ Yes *If yes, where?* _____
- HOW OFTEN does your child experience the problem?
  ❑ always ❑ often ❑ occasionally ❑ rarely ❑ monthly ❑ weekly ❑ daily (❑ AM / ❑ PM)
- WHEN is the problem at its worst? ❑ Morning ❑ Mid-day ❑ Evening ❑ Other _____
- What RELIEVES the problem? _____ What makes the problem WORSE? _____

Are there any SECONDARY health concerns you wish to bring to our attention?

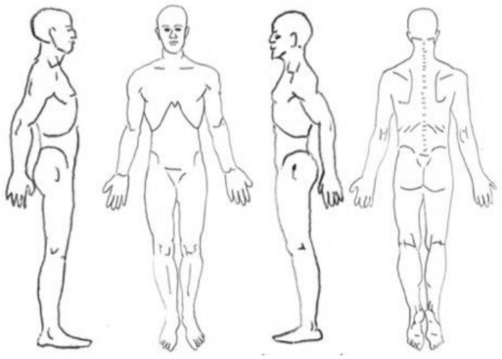
PROBLEM/CONCERN #2: ❑ N/A_____

- Rate your child's CURRENT pain/discomfort: ___ /10 WHEN did the problem begin? _____
- Did your child do something/did something happen that caused/aggravated the problem?
  ❑ No ❑ Yes If yes, explain: _____
- Does the problem RADIATE outward? ❑ No ❑ Yes If yes, where? _____
- HOW OFTEN does your child experience the problem?
  ❑ always ❑ often ❑ occasionally ❑ rarely ❑ monthly ❑ weekly ❑ daily (❑ AM / ❑ PM)
- WHEN is the problem at its worst? ❑ Morning ❑ Mid-day ❑ Evening ❑ Other _____
- What RELIEVES the problem? _____ What makes the problem WORSE? _____

Directions: On the diagrams to the RIGHT, CIRCLE the area(s) that to your child's pain/symptom(s):

How would you describe the problem(s)?

❑ Dull ache ❑ Deep/boring ❑ Numb
❑ Pounding ❑ Stiff/tight ❑ Sharp/stabbing
❑ Radiating ❑ Tingling ❑ Burning
❑ Other: _____



CHIROPRACTIC & HEALTH LIFESTYLE GOALS

What are the health and lifestyle goals you hope your child achieves while under chiropractic care?

PLEASE CHECK ALL THAT APPLY:

❑ Decrease the severity & intensity of my child's pain/problem(s)
❑ Decrease the frequency of my child's pain/problem(s) (how often my child experiences the pain/problem(s))
❑ By the end of my child's corrective chiropractic care, I hope they are able to… _____

ACTIVITIES OF DAILY LIVING

DIRECTIONS: Assess your child's ability / lack of ability to complete the following activities.

	CAN COMPLETE			CANNOT	
	Without Pain or Difficulty	With Minimal Pain or Difficulty	With Significant Pain or Difficulty	COMPLETE Due to Pain	N/A
Activity	❑	❑	❑	❑	❑
Bathe/Shower	❑	❑	❑	❑	❑
Brush Hair	❑	❑	❑	❑	❑
Brush Teeth	❑	❑	❑	❑	❑
Use Toilet	❑	❑	❑	❑	❑
Get Dressed	❑	❑	❑	❑	❑
Stand	❑	❑	❑	❑	❑
Walk	❑	❑	❑	❑	❑
Sit	❑	❑	❑	❑	❑
Squat	❑	❑	❑	❑	❑
Kneel	❑	❑	❑	❑	❑
Reach Overhead	❑	❑	❑	❑	❑
Bend Forward	❑	❑	❑	❑	❑
Turn Left	❑	❑	❑	❑	❑
Turn Right	❑	❑	❑	❑	❑
Move from Seated to Standing	❑	❑	❑	❑	❑
Sleep	❑	❑	❑	❑	❑
Eat	❑	❑	❑	❑	❑
Go up/Down Stairs	❑	❑	❑	❑	❑
Get In/Out of Car	❑	❑	❑	❑	❑
Drive	❑	❑	❑	❑	❑
Use Computer	❑	❑	❑	❑	❑
Focus/Concentrate	❑	❑	❑	❑	❑
Prepare Food	❑	❑	❑	❑	❑
Householdd Chores	❑	❑	❑	❑	❑
Carry Bag/Purse	❑	❑	❑	❑	❑
Run/Hike	❑	❑	❑	❑	❑
Other:_____	❑	❑	❑	❑	❑

REVIEW OF SYSTEMS & ORGAN DYSFUNCTION

DIRECTIONS: Check the box(es) that apply to conditions that your child/your child's family members currently suffer from/have suffered from in the past. (Was your child Adopted? ❑ No ❑ Yes)

CONDITION	YOUR CHILD	CHILD'S SIBLING	CHILD'S PARENT	CHILD'S GRANDPARENT
Acid Reflux/Heartburn/GERD	❑	❑	❑	❑
ADHD/ADD	❑	❑	❑	❑
Allergies	❑	❑	❑	❑
Anxiety	❑	❑	❑	❑
Arthritis/Joint Pain	❑	❑	❑	❑
Asthma/Difficulty Breathing	❑	❑	❑	❑
Autism Spectrum	❑	❑	❑	❑
Cancer	❑	❑	❑	❑
Carpal Tunnel Syndrome	❑	❑	❑	❑
Chest Pain	❑	❑	❑	❑
Depression	❑	❑	❑	❑
Diabetes	❑	❑	❑	❑
Difficulty Sleeping	❑	❑	❑	❑
Disc Problems	❑	❑	❑	❑
Dizziness/Vertigo	❑	❑	❑	❑
Ear Problems	❑	❑	❑	❑
Epilepsy	❑	❑	❑	❑
Fibromyalgia	❑	❑	❑	❑
Headaches/Migraines	❑	❑	❑	❑
Hemorrhoids	❑	❑	❑	❑
Hgh/Low Blood Pressure	❑	❑	❑	❑
Infertility	❑	❑	❑	❑
Irritable Bowl Syndrome	❑	❑	❑	❑
Menstrual Dysfunction	❑	❑	❑	❑
Mood Changes/Irritability	❑	❑	❑	❑
Numbness/Tingling	❑	❑	❑	❑
Scoliosis	❑	❑	❑	❑
Sinus Problems	❑	❑	❑	❑
Swelling of Legs/Feet	❑	❑	❑	❑
TMJ/Jaw Pain	❑	❑	❑	❑
Tremors	❑	❑	❑	❑
*Organ/System Problems	❑	❑	❑	❑

* Select ALL that apply: ❑ Digestive ❑ Gallbladder ❑ Heart ❑ Liver ❑ Stomach ❑ Pancreas ❑ Reproductive ❑ Lung/Respiratory ❑ Urinary ❑ Kidney ❑ Prostate ❑ Vision ❑ Thyroid ❑ Skin ❑ Sexual ❑ Other(s) _____ Explain: _____

REBELUTION HEALTHCARE

Informed Consent for Diagnostic and Treatment Procedures

I have received my examination and the doctor explained to me what he/she found. Based on this, I give my permission to have diagnostic tests, procedures, and a treatment plan for my condition(s). I understand that the treatment I receive at this clinic is from a licensed Doctor of Chiropractic. Chiropractic scope of practice includes a wide range of services, but if the clinician determines the services I need cannot be provided by this office, then he/she will direct me to the appropriate health care provider.

Within the service provided by this office, treatment almost always includes either physical therapy procedures including exercise, manual therapy, and functional activities or the chiropractic adjustment, a specific type of joint manipulation. Spinal manipulation and physical therapy modality procedures are done to ease pain and/or help the body function better. Like most health care procedures, the spinal manipulation and physical therapy procedures carry with it some risks. Unlike many such procedures, the serious risks associated with the spinal manipulation and physical therapy procedures are extremely rare. **The following are the potential risks:**

- **Temporary soreness or increased symptoms or pain.** It is not uncommon for patients to experience temporary soreness or increased symptoms or pain after the first few treatments.
- **Dizziness, nausea, flushing:** These symptoms are relatively rare. It is important to notify the doctor if you experience these symptoms during or after your care.
- **Fractures:** When patients have underlying conditions that weaken bones, like osteoporosis, they may be susceptible to fracture. It is important to notify your doctor if you have been diagnosed with a bone weakening disease or condition. If your doctor detects any such condition while you are under care, you will be informed, and your treatment plan will be modified to minimize risk of fracture.
- **Disc herniation or prolapse:** Spinal disc conditions like bulges or herniations may worsen even with chiropractic care. It is important to notify your doctor if symptoms change or worsen.
- **Stroke:** According to the most recent research, there is no evidence of excess risk of stroke associated with chiropractic care. Regarding neck pain and headache symptoms, there is an association between stroke and visits to all provider-types, including primary care medical visits, which may occur before or during the provider visit.
- **Other risks:** associated with chiropractic treatment include rare burns from physiotherapy devices that produce heat.
- **Bruising:** Instrument assisted soft tissue manipulation may result in temporary soreness or bruising.
- **Alternatives** to manipulation discussed through a shared decision-making process include: Medicines, Physical Therapy, Massage, Mobilization, Acupuncture, and/or Cognitive-behavioral therapy. You can do these whether or not you are doing spinal manipulation.
- **Refusing diagnostic and/or treatment procedures** may carry a risk to future capabilities in regard to performing activities of daily living or progression towards chronic pain.
  _____ I am not pregnant to my knowledge (date of last menstrual cycle: _____). I have been advised that it may not be advisable to be exposed to x-rays if I believe that there is a possibility that I am pregnant.
- **Spinal Decompression**
  Benefits: The primary indication for non-surgical spinal decompression is painful spine pain, nerve compression, and disc problems including:
  • Herniated Disc
  • Degenerative Disc
  • Facet Syndrome
  • Sciatica
  • Post-surgical Disc
  • Spinal Stenosis
- **Risks of Spinal Decompression:** A common side effect of decompression therapy is a dull, achy soreness for the first week or two as the body becomes accustomed to being stretched and decompressed, because the muscles are stretched in a lengthening direction which the body is not used to. If you have disc fragmentation, calcification, severe arthritis and any surgicial spinal appliances, decompression therapy may not be indicated for you. If you have had any surgery and have surgicial hardware fixation in the region of the spine being targeted, then decompression therapy should not be used. Other Contraindications include:
  • Instabilities of the spine, such as recent fractures
  • Biliteral pars defects
  • Unstable spondylolisthesis (typical grade 2 and above)
  • Gross osteoporosis
  • Cancers or tumors of the spine
  • Surgical hardware fixation in the region of the spine being targeted

I understand that the practice of chiropractic, like the practice of all healing arts, is not an exact science, and I acknowledge that no guarantee can be given as to the results or outcome of my care. The material risks have been disclosed to me, including a description of those material risks; and after consideration, I agree to the procedures understanding any material risks which are inherent to that procedure.

● PATIENT PLEASE REVIEW ● PRINT & SIGN NAME ●

I have read or had read to me this informed consent document. I have discussed or been given the opportunity to discuss any questions or concerns with my doctor and have had these answered to my satisfaction prior to my signing this informed consent document. I have made my decision voluntarily and free

Patient's Name (Print)_____ Date of Birth _____

Patient Guardian/Representative (Print) _____

_____ _____ _____ _____

Patient Guardian/Representative Signature Date Translator/Interpreter Signature Date

I also give my permission for my minor child to receive this treatment without my supervision or presence at each treatment visit.

Patient Guardian/Representative (Print) _____

_____ _____ _____ _____

Patient Guardian/Representative Signature Date Translator/Interpreter Signature Date

ly.

CLINICIAN ONLY

Based on my personal observation, the patient's history and physical exam, I conclude that throughout the informed consent process the patient was:

□ OF LEGAL AGE □ APPEARS UNIMPAIRED □ CONSENT GIVEN THROUGH GUARDIAN/PATIENT REPRESENTATIVE

□ ORIENTED X3 □ FLUENT IN ENGLISH □ ASSISTED BY A TRANSLATOR OR INTERPRETER

–_____**, D.C.** _____

Clinician Signature Date