CHILD CASE HISTORY

ABOUT THE CHILD

Name _____ Date _____

Address _____ City _____ State _____ Zip _____

Birth Date _____ Age _____ Sex M F

Parent(s) Name(s) _____ Home phone _____

Cell Phone _____ E-mail _____

Name of child's other healthcare provider(s) _____

REASON FOR THIS VISIT

What is the reason for your child's visit? _____

_____

When did this condition begin? _____ Has this condition ☐ gotten worse ☐ stayed constant ☐ comes and goes

Is the purpose of this visit related to any of the following?
☐ sports ☐ auto accident ☐ fall ☐ home injury ☐ chronic discomfort ☐ other _____

Have you seen other doctors for this condition? ☐ Yes ☐ No
Doctor's Name(s) _____ Types of Treatment _____
Results of Treatment _____

CHILD HEALTH HISTORY

Has your child experienced any of the following?
☐allergies ☐asthma ☐attention problems ☐breathing problems ☐car accident ☐severe fall ☐broken bone ☐colic ☐constipation ☐bed wetting ☐hyperactivity ☐ear problems ☐pink eye ☐frequent colds/cough ☐digestive problems ☐vision problems ☐headaches ☐difficulty sleeping ☐irritability ☐skin problems ☐ hospitalization/surgery ☐other
Explain any checked: _____
Does your child have any developmental issues/concerns? _____

MOTHER'S PREGNANCY & LABOR

During the pregnancy, did the mother:

- ☐ Experience any illness? List _____
- ☐ Take medications? List _____
- ☐ Smoke or consume alcohol or drugs? List _____
- ☐ Undergo excessive stress? Reason _____
- ☐ Have any complications? List _____

BIRTHING PROCESS

Birthplace: ☐ Home ☐ Hospital ☐ Birthing Center ☐ Other _____
Type of birth: ☐ Vaginal ☐ C-section ☐ Cephalic (head first) ☐ Breech (feet first)
Birth Assistants: ☐ Obstetrician ☐ Midwife ☐ Doula
Was labor chemically induced? Yes ☐ No ☐
Procedures: ☐ Forceps ☐ Vacuum Extraction ☐ Epidural ☐ Episiotomy ☐ Pulling/Twisting of Baby
How long did labor and delivery last? _____
Any complications? _____
Gestational age of child (how many weeks) at birth: _____ Birth weight: _____

Check any of the following if the child experienced it immediately after birth:
☐ Jaundice ☐ Feeding Problems ☐ Respiratory Problems ☐ Displaced or Broken Joints
☐ Other Conditions (s) _____

VACCINATIONS

Is your child vaccinated: Yes ☐ No ☐

If yes, check vaccinations received: ☐ DTP or Tdap/ DTap ☐ MMR ☐ Polio ☐ Chicken Pox ☐ Hepatitis ☐ Flu ☐ Other _____

Any reactions to the vaccine: _____

Was your child breastfed? Yes ☐ No ☐ If yes, for how long? _____

CHILD'S CURRENT HEALTH STATUS

Is your child accident prone? Yes ☐ No ☐

Has your child ever: ☐ been hospitalized ☐ had a severe fall ☐ been in a car accident ☐ taken antibiotics

Explain any checked answers _____

Does your child **CURRENTLY** take any medications and/or supplements? Is Yes, please list:

_____

Does your child have difficulty interaction with schoolmates or friends? ☐ Yes ☐ No

Have you or anyone else noticed that your child in nervous, twitches, shakes, or exhibits 'rocking' behavior? ☐ Yes ☐ No

What changes (if any) in your child's health or behavior would you like accomplished?

_____

_____

GOALS FOR MY CHILD'S CARE

Children see Chiropractors for a variety of reasons. Some go for relief of pain, some to correct the cause of pain and others for correction of whatever is malfunctioning in their bodies. Your Doctor will weigh your needs and desires when recommending your child's Chiropractic care program. Please check the type of care desired so that we may be guided by your wishes whenever possible.

☐ RELIEF CARE – Symptomatic relief of pain or discomfort

☐ CORRECTIVE CARE – Correcting and relieving the cause of the problem as well as the symptoms

☐ COMPREHENSIVE CARE – Bring whatever is malfunctioning in the body to the highest state of health possible with Chiropractic care

☐ I want the Doctor to select the type of care appropriate for my child

_____ _____

Signature of Parent/Guardian Date

CONSENT

I, the undersigned, parent/person having legal custody/guardianship of _____ a minor, do hereby authorize Dr. Cassandra Shum, as agent for the undersigned to consent to any X-ray examination and chiropractic evaluation or care of my child.

_____ _____

Signature of Parent/Guardian Date

Informed Consent Form Chiropractic

The doctor of chiropractic evaluates the patient using standard examination and testing procedures. A chiropractic adjustment involves the application of a quick, precise force directed over a very short distance to a specific vertebra or bone. There are a number of different techniques that may be used to deliver the adjustment, some of which utilize specially designed equipment. Adjustments are usually performed by hand but may also be performed by hand-guided instruments. In addition to adjustments, other treatments used by chiropractors include physical therapy modalities (heat, ice, ultrasound, soft-tissue manipulation), nutritional recommendations and rehabilitative procedures.

Chiropractic treatments are one of the safest interventions available to the public demonstrated through various clinical trials and indirectly reflected by the low malpractice insurance paid by chiropractors. While there are risks involved with treatment, these are seldom great enough to contraindicate care. Referral for further diagnosis or management to a medical physician or other health care provider will be suggested based on history and examination findings.

Listed below are summaries of both common and rare side-effects/complications associated with chiropractic care:

Common [1, 2]

- Reactions most commonly reported are local soreness/discomfort (53%), headaches (12%), tiredness (11%), radiating discomfort (10%), dizziness, the vast majority of which resolve within 48 hours

Rare [3, 4]

- Fractures or joint injuries in isolated cases with underlying physical defects, deformities or pathologies
- Physiotherapy burns due to some therapies
- Disc herniations
- Cauda Equina Syndrome [(2)] (1 case per 100 million adjustments)
- Compromise of the vertebrobasilar artery (i.e. stroke) (range: 1 case per 400,000 to 1 million cervical spine adjustments [manipulations]). This associated risk is also found with consulting a medical doctor for patients under the age of 45 and is higher for those older than 45 when seeing a medical doctor.

Please indicate to your doctor if you have headache or neck pain that is the worst you have every felt[(3)]

I understand that there are beneficial effects associated with these treatment procedures including decreased pain, improved mobility and function, and reduced muscle spasm. I also understand that my condition may worsen and referral may be necessary if a course of chiropractic care does not help or improve my condition.

Reasonable alternatives to these procedures have been explained to me including prescription medications, over-the-counter medications, possible surgery, and non-treatment. Listed below are summaries of concern with the associated alternative procedures.

- Long-term use or overuse of medication carries some risk of dependency with the use of pain medication the risk of gastrointestinal bleeding among other risks
- Surgical risks may include unsuccessful outcome, complications such as infection, pain, reactions to anesthesia, and prolonged recovery[5].
- Potential risks of refusing or neglecting care may result in increased pain, restricted motion, increased inflammation, and worsening of my condition[6]

Neck and back pain generally improve in time, however, recurrence is common. Remaining active and positive improve your chances of recovery.

1. Thiel HW, Bolton JE, Docherty S, Portlock JC. Safety of chiropractic manipulation of the cervical spine: a prospective national survey. *Spine.* Oct 1 2007;32(21):2375-2378; discussion 2379.
2. Rubinstein SM, Leboeuf-Yde C, Knol DL, de Koekkoek TE, Pfeifle CE, van Tulder MW. The benefits outweigh the risks for patients undergoing chiropractic care for neck pain: a prospective, multicenter, cohort study. *J Manipulative Physiol Ther.* Jul-Aug 2007;30(6):408-418.
3. Cassidy JD, Boyle E, Cote P, et al. Risk of vertebrobasilar stroke and chiropractic care: results of a population-based case-control and case-crossover study. *Spine.* Feb 15 2008;33(4 Suppl):S176-183.
4. Boyle E, Cote P, Grier AR, Cassidy JD. Examining vertebrobasilar artery stroke in two Canadian provinces. *Spine.* Feb 15 2008;33(4 Suppl):S170-175.
5. Carragee EJ, Hurwitz EL, Cheng I, et al. Treatment of neck pain: injections and surgical interventions: results of the Bone and Joint Decade 2000-2010 Task Force on Neck Pain and Its Associated Disorders. *Spine.* Feb 15 2008;33(4 Suppl):S153-169.
6. Carroll LJ, Hogg-Johnson S, van der Velde G, et al. Course and prognostic factors for neck pain in the general population: results of the Bone and Joint Decade 2000-2010 Task Force on Neck Pain and Its Associated Disorders. *Spine.* Feb 15 2008;33(4 Suppl):S75-82.

PLEASE DO NOT SIGN THIS FORM UNTIL AFTER YOUR TREATMENT PLAN HAS BEEN REVIEWED WITH YOU BY YOUR DOCTOR

Please answer the following questions to help us determine possible risk factors:

QUESTION	YES	DOCTOR'S COMMENTS
GENERAL		
Have you ever had an adverse (i.e. bad) reaction to or following chiropractic care?	☐	
BONE WEAKNESS		
Have you been diagnosed with osteoporosis?	☐	
Do you take corticosteroids (e.g. prednisone)?	☐	
Have you been diagnosed with a compression fracture(s) of the spine?	☐	
Have you ever been diagnosed with cancer?	☐	
Do you have any metal implants?	☐	
VASCULAR WEAKNESS		
Do you take aspirin or other pain medication on a regular basis?	☐	
If yes, about how much do you take daily? _____		
Do you take warfarin (coumadin), heparin, or other similar "blood thinners"?	☐	
Have you ever been diagnosed with any of the following disorders/diseases?		
• **Rheumatoid arthritis**	☐	
• **Reiter's syndrome, ankylosing spondylitis, or psoriatic arthritis**	☐	
• **Giant cell arteritis (temporal arteritis)**	☐	
• **Osteogenesis imperfecta**	☐	
• **Ligamentous hypermobility such as with Marfan's disease, Ehlers-Danlos syndrome**	☐	
• **Medial cystic necrosis (cystic mucoid degeneration)**	☐	
• **Bechet's disease**	☐	
• **Fibromuscular dysplasia**	☐	
Have you ever become dizzy or lost consciousness when turning your head?	☐	
SPINAL COMPROMISE OR INSTABILITY		
Have you had spinal surgery?	☐	
If yes, when? _____		
Have you been diagnosed with spinal stenosis?	☐	
Have you been diagnosed with spondyliolithesis?	☐	
Have you had any of the following problems?		
• **Sudden weakness in the arms or legs?**	☐	
• **Numbness in the genital area?**	☐	
• **Recent inability to urinate or lack of control when urinating?**	☐	

I have read the previous information regarding risks of chiropractic care and my doctor has verbally explained my risks (if any) to me and suggested alternatives when those risks exist. I understand the purpose of my care and have been given an explanation of the treatment, the frequency of care, and alternatives to this care. All of my questions have been answered to my satisfaction. I agree to this plan of care understanding any perceived risk(s) and alternatives to this care.

PATIENT [or PARENT/GUARDIAN] SIGNATURE _____ **DATE** _____

INTERN SIGNATURE _____ **DATE** _____

DOCTOR'S SIGNATURE _____ **DATE** _____

arcadia health chiropractic
DR. CASSANDRA SEPULVEDA INC.

AHC OFFICE POLICIES & PATIENT FINANCIAL RESPONSIBILITY

Thank you for choosing Arcadia Health Chiropractic for your health care needs. We are honored by your choice and are committed to providing you with the highest quality of care.
We ask that you take a moment to thoroughly read and sign this form to acknowledge your understanding of our office policies and financial agreement which are as follows:

FINANCIAL AGREEMENT

- The patient is ultimately fully responsible for the payment of all charges or fees for services provided, regardless of any contract of insurance, any action at the court, any settlement, structured settlement, verdict, or arbitration award which may be received or be due, or the course of outcome of any dispute regarding the same.
- The patient is aware that failure to pay for his/her treatment and care will result in the collection actions being taken to collect debt (i.e. being sent to collections agency)
- The patient is responsible for any costs associated with the collection of patient balances
- The office charges a $30 fee for non-sufficient funds for returned checks.
- PrePaid packages expire 12 months from the date of purchase and are non-refundable/non-transferable. Any remaining balance on your plan after this time can be credited towards regular visits at the current pricing schedule.

INITIAL _____

NEW PATIENT APPOINTMENTS
All new patient appointments require a $100 deposit to reserve your appointment. This deposit will then be applied to your first visit. Failure to cancel or reschedule this appointment with at least a 24 hour notice will result in a loss of this deposit.

INITIAL _____

SCHEDULING APPOINTMENTS
Please respect our time and let us know at least 24-hours in advance if it is necessary to reschedule your appointment – we may have other patients who would like to schedule an appointment during your original time slot. Our office staff usually sends appointment reminders whenever possible as a *courtesy*, however it remains ***your responsibility*** to remember your appointment day and time in event you do not receive a reminder.

INITIAL _____

LATE CANCELLATION/NO SHOW FEES
Failure to contact us at least 24 hours in advance to cancel/reschedule your appointment will result in the ***full cost*** of your appointment that will be due on your next visit. If you are under a pre-paid treatment plan, one visit will be deducted from your plan.

INITIAL _____

LATE APPOINTMENT ARRIVALS
If you are running more than ten minutes late to your appointment, please contact us as it may be possible that your office visit will be shorter than normal or need to be rescheduled. Dr. Sepulveda may be able to see you in the remaining time only if it does not compromise the quality of your care or another patient's appointment time.

INITIAL _____

I, (print name)_____understand and agree to the terms of this policy.

_____ _____
Signature **Date**