RCWC
Rolnick Chiropractic
Wellness Centre

Hi!

We are so glad that you have chosen our office to help your child's journey towards health and wellness.

There are a few forms to complete prior to your arrival at the office. Please allow yourself 10-15 minutes to fill them out in their entirety.

> The Health History form gives us information about your child's current health concerns as well as their health history. Please be as thorough as possible ***and make sure to fill out front and back.*** The more information given to us, the better equipped we are to understand the condition of your child's body, how it got to this point and how best to care for them.

You will find additional forms which require your review and signature as well. Please bring all the completed forms to the office at your visit.

If for any reason you are unable to keep this appointment, please call our office as soon as possible.

We're looking forward to meeting you and your child!

Sincerely,

Eleanor L. Rolnick, D.C.

Shannon Connors

New Patient Coordinator

Eleanor L. Rolnick, D.C.
413 Alfred St. • Biddeford, ME 04005
Tel: (207) 283-1168 • Fax: (207) 282-5248 • www.rolnickchiropractic.com

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Child Health History

NAME: _____ DATE: _____

PARENTS/GUARDIAN: _____

ADDRESS: _____

CITY/STATE: _____ ZIP CODE: _____

HOME PHONE: _____ WORKPHONE: _____

BIRTHDATE: _____ OTHER CHILDREN NAMES/AGES _____

_____

WHO REFERED YOU TO THIS OFFICE: _____

PAST CHIROPRACTIC CARE? YES/NO, DR.'S NAMES/LOCATION: _____

_____ LAST VISIT: _____

CURRENT MEDICAL CARE? YES/NO WHY: _____

CURRENT DRUGS/MEDICATION: _____

REASON FOR CONSULTING THIS OFFICE: _____

_____

PLEASE CHECK THE CHOICE THAT MOST CLOSELY DESCRIBES CURRENT GOALS FOR YOUR CHILD'S HEALTH/WELLBEING.

- ☐ I am only concerned about relief of a particular symptom.
- ☐ I am only concerned about relief of a particular symptom and preventing its return.
- ☐ I want optimum health and wellbeing on every level for my child.

WE ACCEPT PAYMENT BY CASH, CHECK AND CREDIT CARD

I understand that all services are to be paid in full at the time of service, unless other arrangements have been made and agreed upon writing.

Signature: _____ Date: _____

413 Alfred Street Biddeford, ME 04005 207-283-1168 rolnickchiropractic.com info@rolnickchiropractic.com

The human body is designed to express health and function normally. However, events may occur in life, which can interfere with this natural ability.

These stressors are the most common cause of subluxations or nerve interference.

Stress may be physical, chemical, or emotional.

Our goal is to reduce the subluxation(s) as much as possible while teaching you and your child(ren) how to stop recreating them.

PLESE TELL US ABOUT ANY STRESS ASSOCIATED WITH BIRTH:

(Please circle any that apply)

During Pregnancy:

1) Drugs/medicine Yes / No
2) Tobacco/alcohol Yes / No
3) Illness during Yes / No

Explain: _____

_____

_____

During Labor & Delivery:

1) Labor chemically induced Yes / No
2) Labor doctor assisted Yes / No
3) C-section delivery? Yes / No
4) Forceps/vacuum extraction? Yes / No
5) Doctor pull or twist baby? Yes / No
6) Premature delivery? Yes / No

Explain: _____

_____

Since Birth:

1) Nursed how long? _____
2) Baby Jaundiced? Yes / No
3) Feeding Problems? Yes / No
4) Sleeping Problems? Yes / No
5) Colic? Yes / No
6) Vaccinations? Yes / No

Explain: _____

_____

_____

_____

_____

_____

_____

_____

_____

PLEASE TELL US ABOUT ANY STRESS ASSOCIATED WITH CHILDHOOD:

1) Any falls or injuries? Yes / No
2) Respiratory problems? Yes / No
3) Ear infections? Yes / No
4) Allergy/Asthma? Yes / No
5) Bedwetting? Yes / No
6) Digestive problems? Yes / No
7) Hyperactivity? Yes / No
8) Other health problems? Yes / No
9) Hospitalized? Yes / No

Explain: _____

_____

_____

_____

_____

_____

_____

_____

Anything else: _____

_____

I hereby authorize the above-named doctor(s) and whoever may be designated as assistants; to provide chiropractic care as may be deemed necessary to my child/ward.

Signature: _____ Date: _____

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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____E-mail: _____

SECTION B: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information ("PHI") to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your PHI, and of other important matters about your PHI. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your PHI that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting Pam Gaudette, C.C.C.A..

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

Rolnick Chiropractic Wellness Centre

Shared Decision Making and Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices.

This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We begin with a health history, followed by the examination procedures indicated. The information we gain along with our clinical experience helps us develop recommendations for any further evaluation, referral and/or care. During the exams, several tests may be preformed, which may include, among others, range of motion, muscle strength, orthopedic, basic neurological testing, and radiographic studies. These tests will be performed to maximize your comfort; however some of these tests may be uncomfortable. There is minimal risk associated with performing these diagnostic procedures. Following your history, examinations, and possible imaging studies, an indicated "next step" recommendation will be made. We may recommend proceeding with chiropractic care, additional studies, or referral to a different provider. For most patients, we are able to proceed with chiropractic care.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. An adjustment serves to improve neurological function as well as restore normal joint motion, reduce swelling and inflammation in a joint, reduce pain in the joint, and improve overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from home administered hot or cold therapies, fractures, disc injuries, strokes, dislocations and sprains. With respect to strokes, there is a rare but serious condition known as a cervical arterial dissection that involves an abnormal change in the wall of an artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. This occurs in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately a percentage of these patients will experience a stroke. As chiropractic can involve manually and/or mechanically adjusting the cervical spine, it has been reported that chiropractic care may be a risk for developing this type of stroke. The association with stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second option and to secure other options about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name: _____ Signature: _____ Date: _____

Parent/Guardian Name: _____ Signature: _____ Date: _____

Witness Name: _____ Signature: _____ Date: _____