113 Oakridge Dr., Mountville, Pa 17554

Pediatric New Patient Information

Date: _____

Patient Information

Child's Name:_____ Child's Nickname:_____

Reason forVisit:_____

Sex: M/F Date of Birth: ___/___/____ Age:_____ Child's SS#_____-_____-_____

Child's Home Phone #: ( )_____

Childs Home Address:_____

Who may we thank for referring you?_____

Family Information

Mothers Name:_____ Fathers Name:_____

Home Phone #_____ Home Phone #_____

Work Phone #_____ Work Phone #_____

Parent's Martial status: (Please check one that applies) Married__ Single__ Divorced___ Widowed__

List Ages of other Children in Family:_____

Predominant language used at home:_____

Consent To Treat

Being the parent or legal guardian of this child, I hereby authorize this office and its doctors to examine and administer care to my son/daughter named _____ as the examining/treating doctor deems necessary.

I understand and agree that I am personally responsible for payment of all fees charged by this office for such care.

Parent's Name:_____ Signature_____

Date:_____ Witnessed by:_____

PRE-SCHOOL CHILD HISTORY

3 years to 5 years

Today's Date _____

Child's Name _____ Sex: M F Date of Birth _____

Age _____

Reason for Today's Visit _____

Yes No

☐ ☐ Does your child complain of pain or discomfort? If yes, when did this occur? _____

Was onset Sudden ☐ or Gradual ☐ Is problem Constant ☐ or Intermittent ☐

Yes No

☐ ☐ Has your child ever had this problem before? _____

Yes No

☐ ☐ Has your child previously been treated for this problem? By whom? _____

Yes No

☐ ☐ Has your child previously had chiropractic care? Previous chiropractor _____

HEALTH HISTORY

Yes No

☐ ☐ Does your child ever complain of back or neck pain? _____

Yes No

☐ ☐ Does your child ever complain of pains in the legs or arms? _____

Yes No

☐ ☐ Does your child ever complain of headaches? _____

Yes No

☐ ☐ Has your child had asthma? _____

Yes No

☐ ☐ Is your child allergic to anything? _____

Yes No

☐ ☐ Are there any smokers in the child's home? _____

Yes No

☐ ☐ Has your child had any earaches ? At what age did the child's first earache occur _____

How frequently does your child have earaches? _____

In which ear do your child's earaches usually occur? Right ☐ Left ☐ Both ☐

Yes No

☐ ☐ Is your child presently taking any prescribed medication ? _____

Please list any other illness which have been a concern for your child

_____

Please list any surgeries your child has had

_____

Yes No

☐ ☐ Do you have any other concerns about your child's health? _____

PRE-SCHOOL CHILD HISTORY

3 years to 5 years

TRAUMA

Yes ☐ No ☐ Has your child had any recent falls or trauma?

Describe the trauma and the date it occurred _____

Yes ☐ No ☐ Has your child ever fallen from a bicycle, skateboard, scooter, rollerblades or similar? _____

Yes ☐ No ☐ Has your child ever fallen down stairs or fallen from a significant height? _____

Yes ☐ No ☐ Has your child ever been in a motor vehicle collision or near-miss? _____

Yes ☐ No ☐ Has your child ever had a bone fracture or joint dislocation? _____

Yes ☐ No ☐ Has your child had any other trauma or injuries? _____

Yes ☐ No ☐ Does your child ever bang his/her head repeatedly against a wall, bed or other object?_____

NUTRITION

Yes ☐ No ☐ Do you have any concerns about your child's diet? _____

Yes ☐ No ☐ Does your child have any food allergies? _____

Yes ☐ No ☐ Does your child have any persistent or intermittently occuring skin rashes? _____

Yes ☐ No ☐ Does your child take vitamin supplements? _____

Yes ☐ No ☐ Does your child eliminate stools each day? _____

For how many months was your child breast-fed? _____

What does your child usually eat for Breakfast? _____

What does your child usually eat for Lunch? _____

What does your child usually eat for Dinner? _____

What does your child usually eat for Snacks?_____

How much cow's milk does your child drink each day?_____

What is your child's favorite food? _____

What type of fast foods does your child like to eat? _____

TOMASETTI FAMILY CHIROPRACTIC

PATIENT POLICIES

Date:_____

WELCOME

The doctor and staff at Tomasetti Family Chiropractic welcome you and want to provide you with the best possible care. We will conduct a thorough history and physical examination to decide if we can assist you. If we do not believe that condition will respond to chiropractic care, we will not accept you as a patient but will refer you to another health care provider, if appropriate.

INSURANCE/PAYMENT FOR SERVICE

In order to keep administrative costs as low as possible, this office DOES NOT process insurance forms directly. We will do our utmost to provide sufficient information for you to obtain reimbursement for your treatment. We have found that in some instances, however, insurance companies will deny or reduce payment despite our best efforts to demonstrate the necessity for care.

I understand and agree that health insurance policies are an agreement between the insurance carrier and myself, and that all services including nutritional supplements rendered me are charged directly to me, and are payable upon receipt of services/supplements. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be due immediately.

ACCEPTANCE AS PATIENT

I understand and agree that the doctor of **Tomasetti Family Chiropractic** has the right to refuse to accept me as a patient at any time before treatment begins. The taking of a history and the conducting of a physical examination are not considered treatment, but are part of the process of information gathering so the doctor can determine whether to accept me as a patient.

MISSED APPOINTMENT

I hereby acknowledge that I will be charged a fee of $40 for missed appointments. An appointment is considered a missed appointment when the patient fails to notify this office of cancellation at least 24 hours prior to the scheduled visit.

LATE APPOINTMENT

An appointment is considered late when the patient arrives more than 15 minutes after the scheduled visit time. Although the patient will still be seen by the doctor, the patient may need to wait for an opening between patients who have arrived on time for their scheduled appointments.

3 MONTH RE-EXAM POLICY
It is the policy of this office to perform a re-exam if a period of 3 months or longer has passed since your last visit with the Doctor. The re-exam fee as well as the adjustment fee will be assessed at this visit.

GOALS AND HELPFUL REMINDERS
The goal of each appointment is to provide the service and care you need in an efficient and reasonable amount of time. If you feel you need more time with the doctor, please tell the staff to schedule the appropriate amount of time

If a new problem arises, an accident occurs, or a consultation is requested, please call as soon as possible to schedule the appropriate amount of time.

Your results are obtained based upon the corrections achieved from visit to visit. If an emergency arises that requires you to miss a scheduled appointment, we ask that you notify us a soon as possible so we may reschedule that appointment for you.

We welcome your family to our office. Please keep children off of the equipment to prevent any injuries from occurring. Children are welcome in the treatment room with an accompanying parent or guardian.

All questions and comments are welcomed. **We are here to help you** be as healthy and well as you want. We recommend that as you near the end of a prescribed supplement that the doctor or staff member re-test you to determine if your body still requires the supplement or whether or not the dosage has changed. The doctor or staff member will test a **maximum** of 3 supplements per visit at no additional charge. If you require 4 or more supplements to be tested in a visit, please let us know as soon as possible so we may allow ample time for nutrient testing. **There will be an additional charge for this service.**

Note: Once a supplement is purchased and opened, office policy prohibits the patient from returning the supplement.

NO PUSH GUARANTEE
You may have been to other doctors' offices where you were made to feel pressured to get more treatment than you were comfortable with. We want you to know that we don't work that way here. We never want you to feel like you're being pushed to get more care than you feel you really need. You are promising to help us improve our service to you by telling us if you ever feel offended or disappointed by the doctor or staff

Patient Signature: _____

This Chiropractic Office is required by law to obtain your informed consent before treatment begins

I, _____ do hereby give my consent to the performance of conservative non-invasive treatment to the joints and soft tissues. I understand that the procedures may consist of manipulations/adjustments involving movement of the joints and soft tissues. Physical therapy and exercises may also be used.

Although spinal manipulation/adjustment is considered to be one of the safest, most effective forms of therapy for neuromusculoskeletal problems, I am aware that there are possible risks and complications associated with these procedures as follows:

Soreness: I am aware that, like exercise, it is common to experience muscle soreness in the first few treatments

Dizziness: Temporary symptoms, like dizziness and nausea can occur but are relatively rare.

Fractures/Joint Injury: I further understand that in isolated cases underlying physical defects, deformities or pathologies like weak bones from osteoporosis, degenerative disc or other abnormality is detected, this office will proceed with extreme caution.

Strokes: Although strokes happen with some frequency in our world, strokes from chiropractic adjustments are rare. I am aware that nerve or brain damage, including stroke is reported to occur one in one million to one in ten million treatments. Once in a million is about the same chance as getting hit by lightning. Once in ten million is about the same chance as a normal dose of aspirin or Tylenol death.

Tests have been performed on me to minimize the risk of any complication from treatment and freely assume these risks

TREATMENT RESULTS

I also understand that there are beneficial effects associated with these treatment function, and reduced muscle spasm. However, I understand there is no certainty that I will achieve these benefits.

I understand the practice of medicine, including chiropractic, is not an exact science and I acknowledge that no guarantee has been made to me regarding the outcome of these procedures.

I agree to the performance of these procedures by my doctor and such other persons of the doctor's choosing.

ALTERNATIVE TREATMENTS AVAILABLE

Reasonable alternatives to these procedures have been explained to me including rest, home applications of therapy, prescription or over-the-counter medications, exercise, and possible surgery.

Medications: Medication can be used to reduce pain or inflammation. I am aware that long-term use or overuse of medication is always a cause for concern. Drugs may mask pathology, produce inadequate or short-term relief, undesirable side-affects, physical or psychological dependence, and may have to be continued indefinitely. Some medications may involve serious risks.

Rest/Exercise: It has been explained to me that simple rest is not likely to reverse pathology, although it may temporarily reduce inflammation and pain. The same is true of ice, heat, or other home therapy. Prolonged bed rest contributes to weakened bones and joint stiffness. Exercises are of limited value but are not corrective of injured nerve and joint tissues

Surgery: Surgery may be necessary for joint stability or serious disk rupture. Surgical risks may include unsuccessful outcome, complications, pain or reaction to anesthesia, and prolonged recovery.

Non-Treatment: I understand the potential risks of refusing or neglecting care may include increases in pain, scar/adhesion formation, restricted motion, possible nerve damage, increased inflammation, and worsening pathology. The aforementioned may complicate treatment making future recovery and rehabilitation more difficult.

To attest to my consent to these procedures, I hereby affix my signature to this Authorization for treatment.

_____ _____

Signature of patient parent or guardian **Date**