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 20-30 minutes to fill them out in their entirety.

> The Health Profile form gives us information about your child's current health concerns and health history. Please be as thorough as possible. 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 him/her.

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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Dr. Eleanor Rolnick
413 Alfred St.
Biddeford, ME 04005

PEDIATRIC CASE HISTORY HEALTH PROFILE

Personal Information

Full name:	**Date:**
Address: Street City State Zip	
Date of birth:	**Age:**
No. of siblings:	**Have you or your child had Chiropractic care before?** **Yes** ☐ **No** ☐
Name of Pediatrician:	
Please list any other health care professionals your child is receiving care from:	
Home phone:	**Work phone:**
Cell phone:	**Email address:**
Best number to contact you:	
Parent/guardian names:	
Parent/guardian Occupations/Employers:	

Finances

We will do our best to explain our fees to you in advance of your acceptance of care. We provide a higher level of care than what many insurance companies cover. Most insurance will cover part of your child's care but will not cover all of it. You are responsible for any portion that is not covered by your insurance plan.

Name of person responsible for account: _____

Does your child have health insurance ? ☐ Yes ☐ No

Name of Insurance Company: _____

Insurance Policy Number: _____

Insurance Co. phone number: _____

Insurance Company address: _____

_____

Addressing Why You are Here:

What brings you here ??

What health condition brings your child to our office? _____

_____

When did the symptoms first begin? _____

How did this problem start? ___ Suddenly ___ Gradually ___Post-Injury

Is this condition ____Getting Worse ____Improving ____Intermittent ____Constant ____Not Sure

What makes the problem better? _____

What makes the problem worse? _____

Has your child ever had a similar condition? ☐ Yes ☐ No

Please explain: _____

Has your child been treated for this problem before? ☐ Yes ☐ No
Please Explain: _____

Physical – Mental – Chemical

Physical traumas (slips, falls, surgeries, car accidents, etc.) : _____

_____

Mental/Emotional traumas (school, friends, relationships, abuse, finances, self-esteem: _____

_____

Chemical traumas (drugs, alcohol, medications, diet, toxins): _____

_____

History of Health Issues

Please mark the following conditions: **P**= Had in the past **C**= Currently have

☐ Allergies	☐ Blood Disorders	☐ Diabetes	☐ Headaches	☐ Neck Pain	☐ Ringing in the ears
☐ Anemia	☐ Broken Bones	☐ Diarrhea	☐ Heart Trouble	☐ Nervousness	☐ Ruptures/Hernias
☐ Arm Problems	☐ Cancer	☐ Digestive Issues	☐ Hyperactivity	☐ Neuritis	☐ Sinus Issues
☐ Arthritis	☐ Chronic Earaches	☐ Dizziness	☐ Irregular Periods	☐ Pleurisy	☐ Stomach Aches
☐ Asthma	☐ Colds/Flu	☐ Eczema	☐ Joint Issues	☐ Pneumonia	☐ Tuberculosis
☐ Back Pain	☐ Constipation	☐ Epilepsy	☐ Menstrual Cramps	☐ Polio	☐ Vaccine Injury
☐ Bed Wetting	☐ Convulsions	☐ Fainting	☐ Migraines	☐ Poor Appetite	☐ Walking Issues
☐ Behavioral Issue	☐ Depression	☐ Growing Pains	☐ Muscle Jerking	☐ Rheumatic Fever	☐ Whooping Cough

Other (please explain) _____

Health History

Child's birth was ☐ At home ☐ At a birthing center ☐ At a hospital

My obstetrician/midwife/family physician was _____

Birth was ☐ Natural vaginal (no medicates/interventions)

☐ C-section: Scheduled OR Emergency

☐ Vaginal with interventions: □ Induction □ Pain medication □ Epidural □ Episiotomy □ Vacuum extraction □ Forceps

List reasons for any interventions/complications: _____

Child's birth weight _____ Child's birth height_____ Current weight _____ Current height _____

APGAR at birth _____ APGAR after 5 minutes _____

Growth & Development

Was your child alert and responsive within 12 hours of delivery? ☐ Yes ☐ No

If no, please explain: _____

At what age did the child: Respond to sound _____ Follow an object _____ Hold head up _____

Vocalize _____ Sit alone _____ Teethe _____ Crawl _____ Walk _____

Patient/Hospitalization/Surgical history (please list below all surgeries, medications, and hospitalizations, including the year it occurred):

_____

Is/was your child breastfed? ☐ Yes ☐ No If yes, how long? _____ Formula introduced at age _____

What type of formula? _____ Introduction of cows milk at age _____ Began solid foods at age _____

Please list any food/juice intolerances or any allergies: _____

Did mother smoke during pregnancy? ☐ Yes ☐ No Did mother drink alcohol during pregnancy? ☐ Yes ☐ No

Any illness of mother during pregnancy? ☐ Yes ☐ No If Yes, please explain including treatment, medications or supplements:

_____

List any drugs/medications (including over the counter or illicit) taken during pregnancy _____

List any supplements taken during pregnancy _____

Any exposure to ultrasound? ☐ Yes ☐ No If yes, how many times and medical reason _____

Has child received any vaccinations? ☐ Yes ☐ No Which ones and list any reactions _____

_____

Has child received any antibiotics? ☐ Yes ☐ No How many times and list reason _____

_____

Average number of hours of TV and/or computer per week _____

Anything else you'd like us to know? _____

_____

I hereby authorize this office and it's doctors to administer care as they so deem necessary to my son/daughter/ward.

Signed: _____ Witnessed: _____ Date: _____

I realize that I am responsible for all fees charged by this office and that I will pay for all services as they are performed.

Signed: _____ Witnessed: _____ Date:_____

AUTHORIZATION TO PAY PHYSICIAN

I hereby authorize the _____ Insurance Company to pay by check made out and mailed directly to:

Rolnick Chiropractic
413 Alfred St
Biddeford, Me 04005

the medical and surgical expense benefits allowable and otherwise payable to me under my current insurance policy, as payment toward the total charges for Professional Services rendered. This payment will not exceed my indebtedness to the above mentioned assignee, and I agree to pay, in a current manner, any balance of said Professional Service charges over and above this insurance payment.

THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.

A photocopy of this Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

Date_____ 20_____

_____ _____
Signature of Policyholder Witness

_____
Signature of Claimant

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:_____ _

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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____E-mail: _____

Patient Number: _____ Social Security Number: _____

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.