Caplan Chiropractic

Pediatric Registration & History

Who referred you?___________________________

PATIENT INFORMATION

Date_____________________________________

Patient Name______________________________

Address__________________________________

____

City State Zip

Sex: ☐M ☐F Age_____ Birth Date_________

Parent or Guardian_________________________

Phone – Home_____________________

Work_______________Cell________________

Best time and place to call__________________

Email____________________________________

Parents Occupation_________________________

Employer_________________________________

Employer Address__________________________

Employer Phone____________________________

Spouse's Name_____________________________

Spouse's Employer_________________________

EMERGENCY CONTACT

Name____________________________________

Relationship_______________________________

Phone _____________________________

PATIENT INFORMATION

Is condition due to an auto accident? ☐Yes ☐No

If yes, date of accident_____________________

To whom have you made a report of your accident?

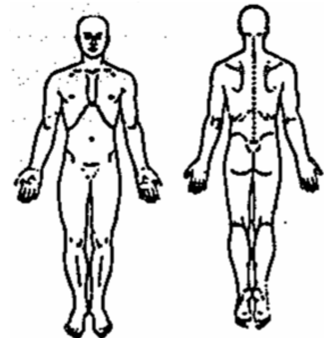
☐Auto Insurance ☐Health Insurance ☐Other__

Attorney Name (if applicable)_______________

Insurance Co. Name_______________________

Insurance Co. Contact______________________

Insurance Co. Contact Phone________________



PATIENT CONDITION

When did your child's symptoms appear?___________________________

Is this condition getting progressively worse (circle one)? Yes No Unknown

Mark an X on the picture where your child continues to have symptoms or discomfort.

Rate the severity of your child's pain on a scale from 1 (least pain) to 10 (severe pain)__________

Type of discomfort (circle all that apply): Sharp Dull Throbbing Aching Numbness

Shooting Burning Tingling Cramps Stiffness Swelling Other ___________________________

How often do these symptoms appear? ____

Is it constant or does it come and go? ____

Does it interfere with your child's (circle all that apply)? Work/School Sleep Daily Routine Recreation

Activities that are difficult for your child to perform (circle all that apply): Nursing, Playing, Sleeping, Sitting

Standing Walking Bending Lying Down

Caplan Chiropractic
6015 Lehman Dr., Suite 202
Phone 719-357-6064

PEDIATRIC MEDICAL HISTORY & EVALUATION

SUBJECTIVE

Your Goals for your Child's care: ____

Your Child's Chief Complaint:____

____

Onset: ____

Descriptors: ____

Aggravating Factors: ____

Relieving Factors: ____

Yellow Flags: ____

______ Night Pain ______ Sitting ______ Sit to Stand ______ Worse A.M. ______ Worse P.M.

PATIENT EDUCATION

Readiness to Learn: Ready & Motivated Limitations (see below)

Limitations to Learning____

MEDICAL HISTORY

Past Medical History:____

____

Medications:____

Treatment to Date:____

PLEASE DESCRIBE YOUR LABOR AND DELIVERY:

____

____

____

____

____

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PATIENT NAME____ DATE_________________________

HEALTH QUESTIONNAIRE

***Height* ________ *Weight* _______**

Health Habits...

Current exercise (Type/ # Times per week): ____

Caffeine Intake (Type/ weekly): ____

Orthotic(s) Usage (Type/ how long): ____

Current Medications (please list both prescription & over-the-counter):________________________

____

Current Vitamins or Supplements (please list): ____

Health Conditions...

Please check any of the following diseases or conditions that your child has now or has ever had in the past. While they may seem unrelated to the purpose of the appointment, they can affect the overall diagnosis, care plan, and the possibility of being accepted for care.

___ Severe or Frequent Headaches	___ Ulcers / Colitis	___ Diabetes
___ Sinus Problems	___ Heart Attack / Stroke	___ Tuberculosis
___ Allergies	___ Blood Clots	___ PID
___ Dizziness	___ Congenital Heart Defect	___ Shingles
___ Concussion/Head Injury	___ Varicose Veins	___ Vision Impairment
___ Loss of Sleep/Irregular Sleep Patterns	___ Heart Surgery/Pacemaker	___ Hearing Impairment
___ Jaw Discomfort	___ Heart Murmur	___ Fatigue
___ Pain Between the Shoulders	___ High / Low Blood Pressure	___ Hepatitis
___ Frequent Neck Pain	___ Difficulty Breathing	___ Cancer
___ Numbness/Pain in Arm/Hand/Legs	___ Osteo/Rheumatoid Arthritis	___ Joint Dislocation
___ Muscle Spasms / Cramps	___ Tendonitis / Bursitis	___ Fracture
___ Sprains (please specify)	___ Surgeries (please specify)	___ Asthma
___ Lower Back Problems	___ Bone or Joint Disease	___ Anxiety
___ Digestive Problems	___ Rheumatic Fever	___ Depression
___ Skin Disorders	___ Anemia	___ Weight Change
___ Memory Loss (Short/Long Term)	___ Alcohol/Drug Abuse	___ Kidney Problems
___ Chemotherapy	___ HIV / AIDS	___ Venereal Disease
___ Psychiatric Problems	___ Vaccinations Type/Last)____________________________	

Was your Child breast fed? Yes No How Long? _________________Briefly describe this experience – positive or negative? ____

Previous Chiropractic: Yes No Good Bad ____

Diagnostic Tests: X-ray MRI CT Scan EMG Other_______________________________

Caplan Chiropractic
Pediatric Office Policies & Information

WELCOME to our office. Please read these policies to ensure your understanding and assist us in providing you with quality care. We will be happy to answer any questions that may arise. These policies and information apply to Children ages 0-8 years old Children 9 and older are considered to be under our standard registration policies.

SERVICE Based on our assessment, we will design a program we feel best suited to reach your Child's goals. Treatment includes Chiropractic care, Active Release Techniques® therapy, possible diet &/or lifestyle re-education based on recommendations for exercise, ergonomics and nutrition. Your Child's first appointment will include both exam and initial treatment and will be approximately 55 minutes. Subsequent appointments are approximately 25 minutes. We will do our best to facilitate your Child's healing process with thorough and effective treatment.

PAYMENT – CASH, CHECK, or CREDIT CARD (MC/VISA) IS DUE AT TIME OF SERVICE. We do not direct bill for any insurance carriers. However, we would be happy to submit an insurance claim to your insurance company upon request. Depending on your policy, you may receive re-imbursement of your out of pocket expenses. Any and all payments received from your insurance company must be payable to Caplan Chiropractic. Once Caplan Chiropractic has processed these payments you will receive any re-imbursement that is due to you. Your insurance company may mail payments for insurance claims originated by Caplan Chiropractic to you (the subscriber). In this case, you (the subscriber) are responsible for bringing any checks received to the Caplan Chiropractic to be processed. Initial _________

☐ I would like Caplan Chiropractic to submit claims to my insurance on my behalf and I agree to bring any checks in to their office to be processed.

☐ No, thank you. I will not need a claim for insurance reimbursement.

Our cash rates for Children ages 0-8 years old are as follows : $135.00 initial visit, $40.00 subsequent visits.

MISSED APPOINTMENTS & CANCELLATIONS – If you are unable to keep your appointment, please let us know 24 hours in advance so we can make it available to other patients. MISSED APPOINTMENTS/CANCELLATIONS with less than a 24-hour notice will result in a full charge.

I have read, understand and agree to the above policies. I agree to be treated at Caplan Chiropractic.

Name: _____________________________________

Signature of Responsible Party (Parent or Gaurdian) ____

I authorize Caplan Chiropractic to charge my credit card for my appointments:

Name on Card:
Credit Card #:
Exp Date:

Authorized Signature:

Caplan Chiropractic
6015 Lehman Ave., Suite 202
Colorado Springs, CO 80918
Phone 719-357-6064

Caplan Chiropractic

Notice of Use of Your Chiropractic & Medical Information

THIS NOTICE DESCRIBES HOW CHIROPRACTIC AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

In the course of your care as a patient at Caplan Chiropractic we may use or disclose personal and health related information about you in the following ways:

- Your protected health information, including your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.
- Your health care records as well as your billing records may be disclosed to another party, such as an insurance carrier, an HMO, a PPO, or your employer, if they are or may responsible for the payment of services provided to you.
- Your name, address, phone number, and your health care records may be used to contact you regarding appointment reminders, information about alternatives to your present care, or other health related information that may be of interest to you.

You have a right to request restrictions on our use of your protected health information for treatment, payment and operations purposes. Such requests are not automatic and require the agreement of this office.

Your name, address, telephone number, e-mail address and health records may be used to contact you regarding appointment reminders, information about alternatives to your present care, or other health related information that may be of interest to you.

If you are not home to receive an appointment reminder or other related information, a message may be left on your answering machine or with a person in your household. You have a right to confidential communications and to request restrictions relative to such contacts. You also have the right to be contacted by alternative means or at alternative locations.

We are permitted and may be required to use or disclose your health information without your authorization in these following circumstances:

- If we provide health care services to you in an emergency.
- If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.
- If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.
- If we are ordered by the courts or another appropriate agency

You have a right to receive an accounting of any such disclosures made by this office.

Any use or disclosure of your protected health information, other than as outlined above, will only be made upon your written authorization. If you provide an authorization for release of information you have the right to revoke that authorization at a later date.

Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

We normally provide information about your health to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your health care or about the status of your account. If you would like to receive this information at an address other than your home, or if you would like the information in a specific form please advise us in writing as to your preferences.

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Colorado Springs, CO 80918
719-357-6064

You have the right to inspect and/or copy your health information for as long as the information remains in our files. In addition you have the right to request an amendment to your health information. Requests to inspect, copy or amend your health related information should be provided to us in writing.

We are required by state and federal law to maintain the privacy of your patient file and the health protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information. We are further required by law to abide by the terms of this notice while it is in effect.

We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice we will notify you in writing as soon as possible following the changes. Any change in our privacy notice will apply for all of your health information in our files.

If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities you should direct your complaint to:
Caplan Chiropractic

If you would like further information about our privacy policies and practices please contact:
Caplan Chiropractic

You also have the right to lodge a complaint with the Secretary of the Department of Health and Human Services. If you choose to lodge a complaint with this office or with the Secretary your care will continue and you will not be disadvantaged by this office or our staff in any manner whatsoever.

This notice is effective as of November 9th 2016. This notice, and any alterations or amendments made hereto will expire seven years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice.

______________________________	______________________________________	____________
Name (Printed)	Signature	Date

If you are a minor, or if you are being represented by another party

______________________________	______________________________________	____________
Personal Representative (Printed)	Personal Representative Signature	Date

____

Please state the description of the authority to act on behalf of the patient.

CAPLAN CHIROPRACTIC

Patient Authorization Regarding Chiropractic Care Being Provided In An “Open-Door” Adjusting Environment

It is the desire of this office to provide chiropractic care in an “open-door” adjusting environment. An “open-door” approach involves the doctor moving from patient care area to patient care area and leaving the doors between patient care areas open. As a result patients are occasionally within sight of one another and some ongoing routine details of care are discussed within earshot of other patients and staff. This environment is used for ongoing care and is NOT the environment used for taking patient histories, performing examinations or presenting reports of findings. These procedures are completed in a private, confidential setting.

We are requesting this authorization of you due to various interpretations under federal law with respect to what is known as an “incidental disclosures” of health information. It is our view that the kinds of matters related in an “open door” environment are incidental matters, in the event you or someone else would not agree with us we are providing this disclosure and requesting your authorization.

The use of this format is intended to make your experience with our office more efficient and productive as well as to enhance your access to quality health care. If you choose not to be adjusted in an open-door adjusting environment other arrangements will be made for you. Your decision will have no adverse effect on your care from Dr. Caplan or on your relationship with our staff.

Your signature indicates your authorization of this activity.

____________________________ ___________________________________ _______

Name (printed) Signature Date

This authorization may be revoked by you at any time. Revocation may be accomplished by advising us in writing of your desire to withdraw your authorization. Please allow a reasonable processing time for the change in our procedures to be completed.

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Caplan Chiropractic

Informed Consent

PATIENT NAME: ___________________________

To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The nature of the chiropractic adjustment

The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis/Examination/Treatment

As part of the analysis, examination, and treatment, you are consenting to the following procedures – please initial each one indicating your consent:

___ spinal manipulative therapy
___ active release techniques (ART)
___ range of motion testing
___ muscle strength testing
___ kinesiotaping
___ hot/cold therapy
___ palpation
___ orthopedic testing
___ postural anaylsis
___ basic neurological testing
___ dietary supplements
___ ultrasound
___ radiographic studies
___ EMS

____

____

The material risks inherent in chiropractic adjustment

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing serious complications including stroke.

Complications of ART include local bruising, fainting, temporary pain or discomfort and the possible temporary aggravation of prior existing symptoms. If you receive dietary supplements the risks include, but are not limited to allergic reactions to supplements.

Some patients will feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibly to inform me.

The probability of those risks occurring

Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for

during the taking of your history and during examination and X-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

The availability and nature of other treatment options

Other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain- medications

If you choose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated

Remaining untreated may allow the formation of adhesions and reduce mobility which may set ip a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE. PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW

I have read [ ] (initial here) or have had read to me [ ] the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Dr. Michelle Caplan and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Dated: ____________

______________________________ **Patient's Name**

______________________________ **Signature**

______________________________ **Signature of Parent or Guardian (if a minor)**

Dated: ____________

Dr. Michelle Caplan, DC
Doctor's Name

____
Signature

Consent to Treatment of Minor

I (we) being the parent or guardian of ______________________________, a minor, the age of _____, do hereby consent, authorize and request Caplan Chiropractic to administer such treatment deemed advisable, necessary or requested on the above minor.

I (we) agree to hold free and harmless from any claims, suits for damages or complications which may result from such treatment.

As of this date I have the legal right to select and authorize health care services for the minor child named above. If my authority to so select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

Signed: ___________________________________Date: _________________________
(Parent or Guardian)

Witnessed: ________________________________ Date: _________________________

Child Neurotransmitter and Nutrition Questionnaire™ (CNNQ)

Name: ____________________ **Age:** _______ **Sex:** _______ **Date:** __________________

Please circle the appropriate number on all questions below (0 as the least/never to 3 as the most/always).

SECTION: GENERAL DIET

- Does your child have any food sensitivities or allergies? (If yes, please list)
- List your child's 4 healthiest foods eaten during the average week.
  ______________ ______________
  ______________ ______________
- List your child's 4 unhealthiest foods eaten during the average week.
  ______________ ______________
  ______________ ______________
- How many times does your child eat candy per week? _______
- How many times does your child drink soda per week? _______
- List the top 4 foods your child craves regularly.
  ______________ ______________
  ______________ ______________
- List the medication(s) your child is currently prescribed and any over-the-counter products used.
- Do you find it difficult to have your child on a special diet?
  ____

SECTION A

- Does your child eat pasta, breads, and breaded foods? **0 1 2 3**
- Does your child have symptoms (fatigue, hyperactivity, etc) after eating foods containing wheat/gluten? **0 1 2 3**
- Does your child consume dairy products? **0 1 2 3**
- Does your child have symptoms (fatigue, hyperactivity, etc) after consuming dairy products? **0 1 2 3**

SECTION B

- Does your child eat fried fish? **0 1 2 3**
- Does your child eat roasted nuts or seeds? **0 1 2 3**
- Is your child missing essential fatty acid-rich foods in his/her diet? (for example: avocados, flax seeds, olives) **0 1 2 3**
  (circle "0" if present, "3" if missing)
- Does your child eat fried foods? **0 1 2 3**

SECTION C

- Is your child's mental speed slow? **0 1 2 3**
- Does your child have difficulty with learning or memory? **0 1 2 3**
- Does your child have difficulty with balance and coordination? **0 1 2 3**

SECTION D

- Does your child have stress? **0 1 2 3**
- Does your child not have enough sleep and rest? **0 1 2 3**
  (circle "0" if enough, "3" if not enough)
- Does your child not have regular exercise? **0 1 2 3**
  (circle "0" if regular exercise, "3" if no exercise)
- Does your child feel overly worried and scared? **0 1 2 3**

SECTION E

- Does your child have temper tantrums? **0 1 2 3**
- Does your child exhibit wild behavior? **0 1 2 3**
- Does your child frequently yell or scream for unnecessary reasons? **0 1 2 3**
- Does your child have an inability to nap or sleep when physically exhausted? (circle "0" if able, "3" if unable) **0 1 2 3**
- Is your child overly talkative? **0 1 2 3**
- Does your child fidget and squirm when seated? **0 1 2 3**
- Does your child run and climb excessively? **0 1 2 3**
- Does your child have difficulty playing quietly or engaging in leisure activities? **0 1 2 3**

SECTION F

- Does your child get excited easily? **0 1 2 3**
- Does your child have anxiety and panic for minor reasons? **0 1 2 3**
- Does your child feel overwhelmed for minor reasons? **0 1 2 3**
- Does your child find it difficult to relax when he/she is awake? **0 1 2 3**
- Does your child have disorganized attention? **0 1 2 3**

SECTION G

- Does your child seem depressed? **0 1 2 3**
- Does your child have mood changes with overcast weather? **0 1 2 3**
- Does your child have symptoms of inner rage? **0 1 2 3**
- Does your child seem uninterested in games or hobbies? **0 1 2 3**
- Does your child have difficulty falling into deep, restful sleep? **0 1 2 3**
- Does your child seem uninterested in friendships? **0 1 2 3**
- Does your child have unprovoked anger? **0 1 2 3**
- Does your child seem uninterested in eating? **0 1 2 3**

SECTION H

- Does your child have difficulty handling stress? **0 1 2 3**
- Does your child have anger and aggression while being challenged? **0 1 2 3**
- Does your child feel tired even after many hours of sleep? **0 1 2 3**
- Does your child tend to isolate himself/herself from others? **0 1 2 3**
- Does your child get distracted easily? **0 1 2 3**
- Does your child have a constant need and desire for candy and sugar? **0 1 2 3**
- Does your child have disorganized attention? **0 1 2 3**

SECTION I

- Does your child have difficulty with visual memory (shapes and images)? **0 1 2 3**
- Does your child have difficulty remembering locations? **0 1 2 3**
- Does your child have fatigue or low endurance for learning activities? **0 1 2 3**
- Does your child have difficulty with attention or a short attention span? **0 1 2 3**
- Does your child have slow or difficult speech? **0 1 2 3**
- Does your child have uncoordinated or slow movements? **0 1 2 3**

Symptom groups listed on this form are not intended to be used as a diagnosis of any disease or condition.

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