FLOW Chiropractic
& Family Wellness Center

2718 Telegraph Ave, Suite 210
Berkeley, CA 94705
PH: 360-402-4550
berkeleyflow.com

Pediatric Patient Introduction

Date:_____

Child's Name:_____ Mother's Name:_____
First Middle Last First Middle Last

Social Security Number:_____ Father's Name:_____
First Middle Last

Address:_____City:_____State:_____Zip:_____

Home Phone:_____ Mother/Father Work Phone:_____

Birth Date:__/__/__ Age:___ Sex: M / F Current Weight:____ Current Height:_____ # of Siblings:_____

Infant Feeding: ___Breast ___Bottle ___Formula

Problems with latching?_____

Number of hours sleep per night:_____ Quality of sleep:___Good ___Fair ___Poor

Name of Obstetrician/Midwife:_____
Name Location

Name of Pediatrician/Family MD:_____
Name Location

Date of last visit to MD:_____Purpose:_____

Previous Chiropractor:_____
Name Location

Immunization History:_____

Purpose of this visit to Flow Chiropractic:_____

If your child has a specific concern, when did it first begin?_____

Have you done anything for, gotten advice for, or sought treatment for this issue? Yes/No

Explain:_____

Result:_____

Is the condition worse during certain times of the day? Yes/No When?_____

What does it impair/impact? __General wellbeing __Interaction with others __Exercise or play __School
__Attitude or mood __Ability to relax or sleep __Day-to-day activities

Has your child ever been treated on an emergency basis? Yes/No

Please describe:_____

Do you have any other concerns about your child's health and wellbeing? Yes/No

Explain:_____

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Mom's pregnancy with this child: Adopted? Yes/No

Indicate if any of the following were present during mom's pregnancy:

___Tobacco ___Alcohol ___Medications ___Recreational drugs ___Falls or injuries ___Abuse ___Stress

Explain any checked:_____

Was it a difficult pregnancy? Yes/No

Third trimester presentation: ___Head down + vertex ___Head down + face/brow ___Breech ___Transverse

Child's birth:

How many weeks gestation at birth?_____ Length of labor:_____

Birth location: ___Hospital ___Home ___Birth Center ___Other

Birth team: ___OB ___Midwife ___Doula ___Partner-assisted ___Family present

Type of birth: ___Vaginal ___Breech ___C-section ___VBAC

Interventions: ___Pitocin ___Epidural ___Ruptured membranes ___Episiotomy ___Assisted pushing
___Vacuum ___Forceps ___Medications ___Restricted movement during labor

Was your child isolated or insulated after birth? Yes/No For how long?_____

APGAR Scores:_____ Was there presence at birth of: ___Jaundice (Yellow) ___Cyanosis (Blue)

Congenital Anomalies/defects?:_____

Authorization for care of Minor

I hereby authorize Flow Chiropractic and doctor(s) to administer care, as they so deem necessary to my son/daughter/ward (upon approval of parent or guardian)

Signed:_____Date:_____

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Informed Consent

I hereby request and consent to the performance of chiropractic adjustments, other chiropractic procedures, including various forms of soft-tissue assessment and release techniques, Craniosacral therapy and subtle energy rebalancing and supportive therapies on me (or on the person named below for whom I am legally responsible) by Ariel Provasoli, DC or any doctors of chiropractic working or associated with or covering at Flow Chiropractic and Family Wellness Center.

I have had the opportunity to discuss with the doctor and/or with other personnel the nature and purpose of chiropractic adjustments. I understand and am informed that, as in the practice of medicine, there are some risks assumed in receiving care and treatment, including, but not limited to, muscle spasms, aggravating and/or temporary increase in symptoms, lack in improvement of symptoms, sprains, fractures, disc injury, stroke and dislocations. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise professional judgment during the course of any procedure which, based on the facts then known, is in my best interest.

Chiropractic care and treatment involves the science, philosophy and art of locating and adjusting spinal interference patterns and misalignments and as such, is oriented toward improving spinal, neurological and muscular functions and ultimately improve health. There has been no promise, implied or otherwise, of a cure for any specific symptom, disease or condition as a result of treatment in this clinic. I understand that the chiropractor will use her hands or a mechanical device upon my body to adjust joints and release muscles, which may cause an audible “click” or “pop” during the procedure.

I further understand that chiropractic adjustments and supportive treatment is designed to reduce and/or correct subluxations, allowing the body to return to improved health. It can also alleviate certain symptoms through a conservative approach with hopes to avoid more invasive procedures. However, like all other health modalities, results are not guaranteed and there is no promise to cure. Accordingly, I understand that all payment(s) for adjustment(s) are final and no refunds will be issued. However, prorated fees for unused, prepaid treatments will be refunded if you wish to cancel the treatment.

I further understand that there are treatment options available for my condition other than chiropractic procedures. These treatment options include but are not limited to self-administered, over the counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; physical therapy; steroid injections; bracing; and surgery. I understand and have been informed that I have the right to a second opinion and can secure other opinions if I have concerns as to the nature of my symptoms and treatment options.

I understand that as part of my healthcare, this Practice originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment. I understand that this information serves as a basis for planning my care and treatment; a means of communication among other health professionals who may contribute to my care; a source of information for applying my diagnosis and treatment information to my bill; and a means by which a third-party payer can verify that services billed were actually provided.

I have read, or have had read to me, the Informed Consent to Chiropractic Adjustments and Care. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

_____ _____

Name (Printed) Date Signed

_____

Signature: Patient or Legal Representative (Attorney, Guardian, Parent)

_____

Witness to Patient’s Signature

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Terms of Acceptance / Philosophical Agreement

When a person seeks chiropractic health care and we accept to provide such care, it is essential that we both have a clear understanding of our objectives, goals, and responsibilities in this special relationship.

The following concepts are central to the way chiropractic is practiced in this office. I share these ideas so that we can be in alignment of purpose from the very beginning.

- There is an intelligence within each of us that keeps us alive, that runs and coordinates all our physiological functions, repairs, renews, regenerates, and heals.
- The Nerve System is the main coordinating and distribution system for the body's innate intelligence.
- Alterations or distortion in the shape, position, tone, or tension of the Nerve System (especially at the spine) will interfere with the expression of this intelligence.
- Chiropractors call this interference to the proper functioning of the Nerve System a Vertebral Subluxation. Subluxation causes alternation in nerve function and distorts the communication channels between the brain and the body. The result is a lessoning of the body's ability to express its maximum health potential.
- Health is a state of optimal physical, mental, and social well-being, not merely the absence of disease, symptoms, or infirmity.
- An Adjustment is the specific and honoring application of forces to facilitate the body's release and integration of subluxation.
- The sole purpose of the chiropractic adjustment in this office is to assist your body to release vertebral subluxation and benefit from the restoration of clear communication channels in the body. Everyone, regardless of their age, symptoms or ailments, will benefit from a nerve system which is more flexible, elastic, and free of vertebral subluxation.
- Chiropractic is not a substitute, an alternative or a preventative form of medicine. We do not offer diagnosis or treatment for specific diseases. Our only practice objective is to eliminate major interferences to the expression of the body's innate wisdom and to support your body to hold and integrate adjustments and healing. If you desire advice, diagnosis, or treatment for specific diseases, we encourage you to seek the council of a medical disease care specialist.

I, _____, have read the above statements and understand the doctor's objectives pertaining to my care in this office. I accept chiropractic care on this basis.

Signature Date

Consent to evaluate and adjust a minor/child:

I, _____, being the parent or legal guardian of _____ have read and fully understand the above terms and acceptance and hereby grant permission for my child to receive chiropractic care in this office.

Signature

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Acknowledgement of Receipt of Notice of Privacy Practices and Consent Form

1. Flow Chiropractic's Privacy Notice has been provided to me prior to signing this consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ('PHI') necessary for FC to provide treatment to me, and necessary for FC to obtain payment for that treatment and to carry out its health care operations. FC explained to me that the Privacy Notice will be available to me in the future at my request. FC has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing consent.

2. FC reserves the right to change the privacy practices that are described in its Privacy Notice, in accordance with applicable law and I will be informed of any revisions.

3. I understand that, and consent to, the following communications that will be used by FC: a) telephoning and leaving a message on my answering machine or with the individual answering the phone; b) a card, letter, or other written information mailed to me at the address provided by me; c) sending an electronic mail to the address provided by me. [Please note: email and text messages are not secure, protected forms of communication. By signing below you are acknowledging your choice to use them to communicate PHI.]

4. FC may use and/or disclose my PHI in order for FC to treat me and obtain payment for that treatment, and as necessary for FC to conduct its specific health care operations.

5. I understand that I have a right to request that FC restricts how my PHI is used and/or disclosed to carry out treatment, payment, and/or health care operations. However, FC is not required to agree to any restrictions that I have requested. If FC agrees to requested restrictions, then the restriction is binding on FC.

6. I understand that this Consent is valid for seven years. I further understand that I have the right to revoke this Consent, in writing, at any time for all future transactions, with the understanding that any such revocation shall not apply to the extent the FC has already taken action in the reliance on this consent.

7. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, FC will not treat me. I further understand that if I revoke this consent, at any time, FC has the right to refuse to treat me.

8. FC may maintain a directory of and sign-in log of individuals seeking care and treatment in this office. This information may be seen by and is accessible to others who are seeking care or services in FC's practice.

9. Visits and spinal adjustments are performed in an open room style with other patients in the same room. Occasionally comments about your symptoms, improvement or lack thereof may be discussed at your office visits. If you have comments or information you wish to share privately when you come into the adjustment room please inform the doctor or staff and we will accommodate your needs.

I acknowledge that I have received a copy of FC's Notice of Privacy Practices. I further acknowledge that a copy of the current notice is posted at the front desk.

We are required by law to maintain the privacy of, and provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please speak with our HIPAA Compliance Officer, Ariel Provasoli. Your signature below is acknowledgment that you have received the Notice of Privacy Practices, and all of your questions have been answered to your full satisfaction in a way that you can understand.

_____ _____

Patients 's Name (printed) Date Signed

_____

Signature (patient or legal representative)