CORDERO
FAMILY CHIROPRACTIC
561-533-3884
WWW.CORDEROCHIROPRACTIC.COM

PEDIATRIC CONSULTATION

Child's Name:_____ Date_____

The majority of children have experienced hundreds of impacts that could cause vertebrae to become misaligned or subluxated. What we need to do now is discover several of the traumas your child has suffered.

What was your child's birth like? Easy/Stressful/Complicated/Surgical

How long was the entire labor?_____How long did you actually push for?_____

Were you induced? ☐ Yes ☐ No Nerve block? ☐ Yes ☐ No C-Section? ☐ Yes ☐ No

Was there any pulling on the head? ☐ Yes ☐ No ☐ Mid-wife OBGYN ☐ Forceps or vacuum extraction

Science has shown that 47% of all children fall on their heads by the age of one and have at least 200 major falls by the age of 5 years old.

When was your child's most recent fall? _____

Was any care given? ☐ Yes ☐ No was he/she checked by a chiropractor for subluxation? ☐ Yes ☐ No

And the fall before that? _____
Any care given? ☐ Yes ☐ No Chiropractic adjustment? ☐ Yes ☐ No

What sports or recreational activities does your child do?_____

When was your child's most recent stress, strain or injury while doing these activities?_____
Any care given? ☐ Yes ☐ No Chiropractic adjustment? ☐ Yes ☐ No

Has your child ever been involved in a motor vehicle accident as a passenger? ☐ Yes ☐ No

Briefly describe: When/Details?_____

Child seat? ☐ Yes ☐ No Seat belt? ☐ Yes ☐ No Front or back seat? ☐ Yes ☐ No

Was care given? ☐ Yes ☐ No Chiropractic adjustment? ☐ Yes ☐ No

This information is important. Thank you for explaining your child's history of accidents and traumas. This will help the doctor better understand where the spine is damaged or subluxated. What we need to do now is ask you a few questions regarding your child's current health concerns.

Does your child have any health concerns? ☐ Yes ☐ No What are they?_____
_____If so, how long have they been present for?_____

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Subluxated vertebra will cause irritation to nerve fibers affecting organs and tissue leading to sickness and illness.

Are there any other conditions your child is or was experiencing? ☐ Yes ☐ No
How long and details?_____

Depending on where and the degree of the subluxated vertebra, nerve pressure can be constant or occasional.

How often does your child have this condition(s)?_____

Does your child take multi-vitamins regularly? ☐ Yes ☐ No What other supplements does your child take?
_____

Please list all medications your child takes: _____

Signature Parent or Guardian:_____Date:_____

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Patient Name:_____ File:_____

Standard Waiver of Liability:

I understand that I am financially responsible for any charges incurred at this office, for those patients using insurance, this would include co-pays, deductibles, and charges denied or not covered by my insurance company.

I realize my care may be subject to pre-authorization by my insurance company, and I accept any responsibility for charges which may not be approved. My insurance company will review any/all documentation submitted by Cordero Family Chiropractic for review for medical necessity, however, final determination is based upon my insurance company's medical guidelines. Insurance policy limitations are per individual insurance policy plans, as are co-payments, co-insurance, deductibles, referrals, etc.

I understand this office agrees to notify me as soon as possible whether my care is approved or denied by my insurance company. I further understand my initial visit may be denied and this may be beyond the office ability to notify me prior to rendering acute care, while waiting for insurance coverage approval. These charges will be my responsibility if denied by my insurance company.

NOTE: our office does not bill secondary insurance carriers.

I understand this office will require payment from me for any services not covered by my health insurance plan. Any payment due beyond 30 days is subject to late fees, interest at 1.5% per month and collection agency fees. I agree to pay all collection costs associated with collecting said debt, including, but not limited to attorney fees of 25% (twenty-five percent), together with the cost and disbursement of the action.

Assignment of Benefits:

I hereby authorize my insurance benefits to be paid directly to Dr. Francisco Colon and/or Dr. Sebastian Colon.

I have read this document and understand my obligations for payments for care in the absence of insurance coverage.

_____

Signature (Patient, Parent/guardian of patient) Date

Release of Medical Records:

I give my permission for Dr. Colon to request medical information for other medical facilities that may help the doctor to accurately assess and treat my current condition.

_____

Signature (patient, or Parent/guardian of patient) Date

Informed Consent for Chiropractic Care

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both of us to be working for the same objective. It is important that each patient understand both the objective(s) and the method(s) that will be used to attain this objective. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition and the recommended care to be provided so that you make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks, and alternatives.

Chiropractic is a science, philosophy and art which concern itself with the relationship between the spinal structure and the health of the nervous system. As chiropractors we understand that health is a state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.

One disturbance to the nervous system is called a vertebral subluxation. This occurs when one or more of the 24 vertebra in the spinal column become misaligned and/or do not move properly. This causes an unhealthy change to nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by a chiropractic adjustment. An adjustment is the specific application of force to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments to the spine. Adjustments are done by hand where the doctor will put pressure on the specific segment(s) of the spine to adjust the vertebrae into a better position.

If at the beginning or during the course of care we encounter a non-chiropractic or unusual findings, we will advise you of those findings and recommend some further testing or refer you out to another health care provider.

Chiropractic care has been proven to be very safe and effective. It is not unusual however, to be sore after your first few corrective adjustments. Although rare it is possible to suffer from other side effects; i.e. muscle spasms, stiffness, rib fracture, headache, dizziness and stroke.

All questions regarding the doctor's objective to my care in this office has been answered to my complete satisfaction. The benefits, risks and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

_____

Print Name 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 Informed Consent and hereby grant permission for my child to receive chiropractic care.

Pregnancy Release

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-rays can be hazardous to an unborn child.

Date of last menstrual cycle:_____

_____