HealthTweak

Our Mission: *Build healthy communities through generations*

Chiropractic Schedule of Fees

Infants (0-2 years)

Consultation + Initial Assessment	$20.00
Chiropractic Visit	$10.00

Children (3-12 years)

Consultation + Initial Assessment	$40.00
Chiropractic Visit	$20.00
Missed appointment without 24 hours' notice	$20.00

HealthTweak

Patient # _____   □ Dr. V. Suprunov, BSc, DC

PERSONAL INFORMATION

Name: _____ Date of Birth: _____ Age: _____

Gender: _____ Height: _____ Weight: _____ Name of Parents/Guardians: _____

Relationship to child: _____ Do you have full custody of the patient: Y / N

Address: _____ City: _____ Postal Code: _____

Phone: _____

E-mail: _____ May we contact you via e-mail? Y / N

Medical Doctor/Pediatrician: _____ Location: _____ Last Visit:_____

How did you hear about us? *□Existing patient* _____ *□Online □ Doctor □Other:*_____

HEALTH CHALLENGES

Please explain your child's health challenge: _____

_____

When did it begin? _____

This challenge started: □ Suddenly □ Gradually □ Unknown

Have you noticed any other symptoms associated with this challenge? _____

Have you seen anyone about this challenge? _____

HEALTH CONDITIONS

Please check any of the following that apply to your child:

□ Ear infections	□ Recurring Fevers	□ Digestive problems
□ Asthma	□ Constipation	□ Bed wetting
□ Allergies	□ Headaches	□ Seizures
□ Colic	□ ADHD	□ Traumatic birth
□ Scoliosis	□ Car accident	□ Diarrhea
□ Temper Tantrums	□ Falls	□ Chronic colds
□ Chicken pox	□ Rubella	□ Whooping cough
□ Rubeola/measles	□ Mumps	□ Adverse vaccination reactions
□ Other _____		

Please list any health conditions in your family history

_____

_____

PRE-NATAL AND CHILDHOOD HISTORY

Complications during pregnancy: _____

Were ultrasounds used during pregnancy? Y / N   How many? _____

Please list any medications during pregnancy? _____

Cigarette/Alcohol use during pregnancy? Y / N   How many? _____

Location of Birth: _____

Birth intervention: ☐ Natural ☐ C-Section ☐ Forceps ☐ Vacuum extraction ☐ Other _____

Delivery complications: _____

Birth Weight: _____ Birth Length: _____ APGAR score:_____

☐ Breast Fed – If yes, how long? _____   ☐ Formula – If yes, how long? _____

Introduced solids at _____ months. Introduced to cow's milk at _____ months.

Please indicate the age able to:

Respond to sound _____ Respond to visual stimuli _____ Crawl _____ Stand _____

Hold head up _____ Walk alone _____ Sit _____

Has there been any surgeries? Please explain: _____

Number of doses of antibiotics your child has taken: _____

Prescription medication your child has taken: _____

Vaccination History: _____

PERSONAL HEALTH INFORMATION CONSENT FORM

I understand that Health*Tweak* is my health information custodian. I consent to the collection, use and disclosure of my personal health information for treatment and other health care reasons. Health*Tweak* is a multidisciplinary clinic, and therefore treatment notes may be shared between practitioners to best treat the patient.

I understand that to provide me with Massage Therapy, Chiropractic, Physiotherapy, or any other health care services, Health*Tweak* will collect personal information about me (e.g. birth date, home contact information, health history, etc.)

I understand that Health*Tweak* will only collect, use, or disclose my personal health information with my express or implied consent; unless a collection, use, or disclosure without consent is permitted or required by law.

Name: _____   Name of Witness: _____

Signature: _____

Date: _____

Thank you for completing this form.

CONSENT TO CHIROPRACTIC TREATMENT

It is important for you to consider the benefits, risks and alternatives to the treatment options offered by your chiropractor and to make an informed decision about proceeding with treatment.

Chiropractic treatment includes adjustment, manipulation and mobilization of the spine and other joints of the body, soft-tissue techniques such as massage, and other forms of therapy including, but not limited to, electrical or light therapy and exercise.

Benefits

Chiropractic treatment has been demonstrated to be effective for complaints of the neck, back and other areas of the body caused by nerves, muscles, joints and related tissues. Treatment by your chiropractor can relieve pain, including headache, altered sensation, muscle stiffness and spasm. It can also increase mobility, improve function, and reduce or eliminate the need for drugs or surgery.

Risks

The risks associated with chiropractic treatment vary according to each patient's condition as well as the location and type of treatment.

The risks include:

♦ **Temporary worsening of symptoms** – Usually, any increase in pre-existing symptoms of pain or stiffness will last only a few hours to a few days.

♦ **Skin irritation or burn** – Skin irritation or a burn may occur in association with the use of some types of electrical or light therapy. Skin irritation should resolve quickly. A burn may leave a permanent scar.

♦ **Sprain or strain** – Typically, a muscle or ligament sprain or strain will resolve itself within a few days or weeks with some rest, protection of the area affected and other minor care.

♦ **Rib fracture** – While a rib fracture is painful and can limit your activity for a period of time, it will generally heal on its own over a period of several weeks without further treatment or surgical intervention.

♦ **Injury or aggravation of a disc** – Over the course of a lifetime, spinal discs may degenerate or become damaged. A disc can degenerate with aging, while disc damage can occur with common daily activities such as bending or lifting. Patients who already have a degenerated or damaged disc may or may not have symptoms. They may not know they have a problem with a disc. They also may not know their disc condition is worsening because they only experience back or neck problems once in a while. Chiropractic treatment should not damage a disc that is not already degenerated or damaged, but if there is a pre-existing disc condition, chiropractic treatment, like many common daily activities, may aggravate the disc condition. The consequences of disc injury or aggravating a pre-existing disc condition will vary with each patient. In the most severe cases, patient symptoms may include impaired back or neck mobility, radiating pain and numbness into the legs or arms, impaired bowel or bladder function, or impaired leg or arm function. Surgery may be needed.

♦ **Stroke** – Blood flows to the brain through two sets of arteries passing through the neck. These arteries may become weakened and damaged, either over time through aging or disease, or as a result of injury. A blood clot may form in a damaged artery. All or part of the clot may break off and travel up the artery to the brain where it can interrupt blood flow and cause a stroke. Many common activities of daily living involving ordinary neck movements have been associated with stroke resulting from damage to an artery in the neck, or a clot that already existed in the artery breaking off and travelling up to the brain. Chiropractic treatment has also been associated with stroke. However, that association occurs very infrequently, and may be explained because an artery was already damaged and the patient was progressing toward a stroke when the patient consulted the chiropractor. Present medical and scientific evidence does not establish that chiropractic treatment causes either damage to an artery or stroke. The consequences of a stroke can be very serious, including significant impairment of vision, speech, balance and brain function, as well as paralysis or death.

Health *Tweak* **is a multidisciplinary clinic; therefore other practitioners may have access to your file. If this poses any concern please let us know.**

Alternatives
Alternatives to chiropractic treatment may include consulting with other health professionals. Your chiropractor may also prescribe rest without treatment, or exercise with or without treatment.

Questions or Concerns
You are encouraged to ask questions at any time regarding your assessment and treatment. Bring any concerns you have to the chiropractor's attention. If you are not comfortable, you may stop treatment at any time.

Please be involved in and responsible for your care.
Inform your chiropractor immediately of any change in your condition.

DO **NOT** SIGN THIS FORM UNTIL YOU MEET WITH THE CHIROPRACTOR

I hereby acknowledge that I have discussed with the chiropractor the assessment of my condition and the treatment plan. I understand the nature of the treatment to be provided to me. I have considered the benefits and risks of treatment, as well as the alternatives to treatment. I hereby consent to chiropractic treatment as proposed to me.
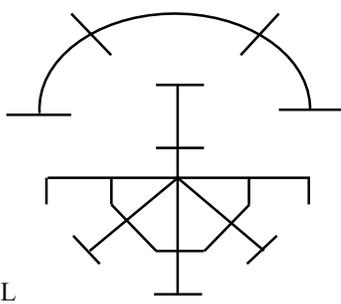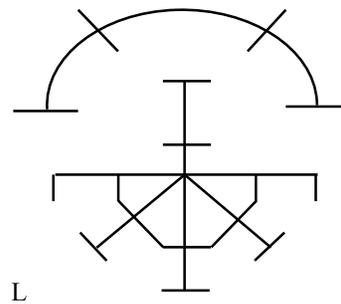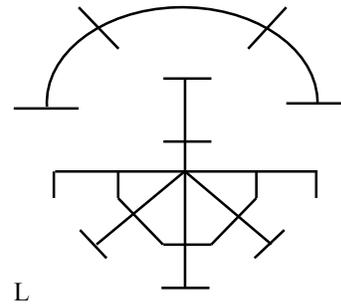
_____
Name *(Please Print)*

_____   _____
Signature of Patient (or legal guardian)   Date

_____   _____
Signature of Chiropractor   Date

Date:	Pain = 0; <1/3 ROM = 1; <2/3 ROM = 2; >2/3 ROM = 3 // Negative orthopedic test = 3; positive test = 0
	Pain = 0; severe tightness/can't hold muscle = 1; tightness or 4/5 muscle test = 2; loose or 5/5 muscle test = 3

C/S ROM:

L

T/S ROM:

L

L/S ROM:

L

Hips/knee

Int Rot:	R_____	L_____
Ext Rot:	R_____	L_____
Flexion:	R_____	L_____
Extension:	R_____	L_____

GH/Wrist/Ankle

Int Rot:	R_____	L_____
Ext Rot:	R_____	L_____
Flexion:	R_____	L_____
Extension:	R_____	L_____
Lateral:	R_____	L_____
Medial:	R_____	L_____
Eversion:	R_____	L_____
Inversion:	R_____	L_____

Muscle Strength 1-5/ Tightness (T)

	L	R		L	R		L	R
Subocc			Supra			Hamstring		
Traps			Infra			TFL		
Levator			Subsc			IT Band		
Scalenes			Bicep			Gl Med		
Lats			Wrist Fl			Gl Max		
SCMs			Wrist Ex			Poplit		
Masset			L/S Err			Peron		
Pec Maj			QL			Sup Calf		
Pec Min			Purif			Deep Calf		
Subclav			Psoas			Tib Ant		
Delts			Quad					
Post Gh			Adduct					/

Neurological Exam (no scoring)

	Motor		Sensory		Reflexes	
	L	R	L	R	L	R
C5	/5	/5			+	+
C6					+	+
C7					+	+
C8					+	+
T1					+	+
L4	/5	/5			+	+
L5					+	+
S1					+	+

☐ CN: 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12

Orthopedic Testing

	L	R
Valsalva		
SLR		
Kemps C/S		
Kemps L/S		
Jackson's		
Spurling's		
Axial Compression		
SI Compression		
Figure 4		
Thigh Thrust		
Prone Instability		
Open Can		
Closed Can		
O'Brien's		
Other:		
Other:		
Other:		

Ant head carry:

_____ in x 10lb = _____ lb

Chest expansion: _____ cm (>5)

Pulse rate: _____

Blood Pressure: _____

SpO2: _____

Perfusion index: L _____ R_____

Pupil symptoms:

L _____ sec. R _____ sec.

Eye tracking:

L _____   R _____

Posture

Head tilt: R / L

Tandem stance: _____ -- _____

March in place eyes closed:

_____ -- _____

Right:
C 1 2 3 4 5 6 7 T1 2 3 4 5 6 7 8
9 10 11 12 L1 2 3 4 5 S1 SI

Left:
C 1 2 3 4 5 6 7 T1 2 3 4 5 6 7 8
9 10 11 12 L1 2 3 4 5 S1 SI

Notes

Palpation

Other