RESONATE WELLNESS CHIROPRACTIC

Thank you for choosing us for your wellness needs.

You are about to engage in a journey that will at least provide an opportunity to improve the health of your child. It could even change their life. Every patient is evaluated for their chief complaint based on need regarding level of health.

What I DO:

----------The Science and Art: ----------

- Muscle testing – Strength, Functional Nerve/Reflex
- Chiropractic Adjustments – Instrument/Manual
- Palpation/Range of Motion
- Nutritional/Dietary Counsel
- Emotional Reflex Therapy (ERT/NET)
- Neurological Testing, Therapies & Rehabilitation (QN) including: Hot/Cold, Light, Taping
- Body-Mind/Spirit exploration: may include prayer, emotion, spiritual matters to address physiology

----------The Philosophy: ----------

- We are a spiritual being held in a physical body; where issues of a physical nature may or may not only have a physical correction but also an emotional or spiritual one.
- The body has the ability to heal and is the master at doing so when it communicates in all areas and systems without interruption: body-mind and spirit.
- The practitioner is a **facilitator of healing**, not the healer. We don't ***FIX*** anything but rather assist the individual to become aware of weaknesses, discover blocks preventing their healing, then facilitate correction.
- Healing takes time. Being patient with your process without forcing it is the preferred and most efficient way to bring change. Forcing issues can actually slow progress in some cases.
- ADIO – we develop and heal from above, down and inside, out.
- With a little guidance and proper information, patients can take responsibility for choosing what's best for their health. Our goal is to empower each to learn awareness of their issues and make their best choice. It is the responsibility of the patient to comply with recommendations to get the best result.

What I DO NOT:

Counselor of the mind – All emotion starts as a physiological response to a stimulus. Although difficult situations may be discussed, it is minimal and only to arrive at an idea that generates physiological response. We do not seek to change behavior. Patients are encouraged to journal for personal benefit and by doing so, may reveal additional patterns where ERT/NET will help. When necessary, referrals to proper mental health professionals will be provided.

Pastor/theologically trained - Although I am a follower of Jesus Christ, I am not a spiritual advisor or pastor. Any and all experiences shared are from the personal perspective of a Christian world view. I do not hide my beliefs nor seek to convert followers. While I respect those of other faiths, I do not have personal knowledge of those and have no intention to offend when information may conflict.

What's different about this care?

Chiropractic is the science, philosophy and art of finding and correcting the subluxation. Since the nervous system is central to the health of the individual, assessing the dysfunction of it first and locating what changes as a result, enables us to navigate the misalignments in the spine from the inside out. Seeking to bring awareness to the system where interference has been ignored, allows a more efficient and even permanent change, causing lasting resolution. It's the why behind the misaligned. (see next page triad of health & video links)

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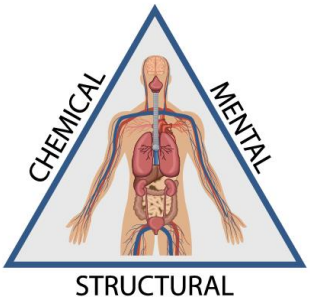

Visit Dr. Parker's website for information about her approach to care:

https://resonatewellnesschiro.com/services/

- - - - - - - - - - - - - - - - - - For PATIENT USE - - - - - - - - - - - - - - - - - -

***Patient Notes**: Make note of any questions to ask on your child's first visit about care, the videos you watched, the techniques used for treatment and any of the forms you will sign in the following pages:*

Please do not sign attached consent forms unless your questions have been satisfied

Resonate Wellness Chiropractic PEDIATRIC PATIENT INFORMATION

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Child Information

Name: _____ Date: _____ Birthday (M/D/Y): _____
Address/City/Zip: _____
Age: _____ Height/Weight: _____/_____ Gender: (M / F) Parent Cell: _____
Emergency Contact Name/Relationship: _____ Phone: _____
Parents Name(s) _____
Phone number: _____ Alt. Phone number: _____
Parent's E-mail: _____ Appt Reminders: ▢ Text ▢ Email
Who may we thank for your referral? _____
Do you have a spiritual practice? If so, what? _____
Family Doctor Name & Clinic: _____
Prof. Designation: _____ Date/Reason of Last Visit: _____

Other Healthcare Professionals: Medical Specialist, Naturopathic Doctor, Counselor, etc.

Name & Clinic: _____
Prof. Designation: _____ Date/Reason of Last Visit: _____
Name & Clinic: _____
Prof. Designation: _____ Date/Reason of Last Visit: _____

- Has your child received previous chiropractic care? ▢ Yes ▢ No
- Why have you decided to have your child evaluated by us?

☐ He/She is continuing ongoing care from another chiropractor.
☐ I have concerns about his/her health and I'm looking for answers.
☐ I want to improve my child's immune function
☐ I recently had my spine checked and understand the value in getting my child checked.
☐ He/She has a specific condition and I've learned that chiropractic may be able to help
Other:_____

- Do you have a specific concern that brings you in?

▢ No - We want a nervous system and general wellness assessment for optimal health
▢ Yes - If yes, please answer the following questions:

• Does your child appear to be in pain or discomfort?	
• How long has your child been experiencing this?	
• Is it getting better, worse or staying the same?	
• Was the onset sudden or gradual?	
• Who, if anyone else, have you seen regarding this complaint?	
• What treatment did they use?	
• Has your child taken any medication for this complaint? If so which:	
• Has your child ever experienced this complaint before?	
• Did they receive any treatment at that time?	
• Had x-rays taken for it?	

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What is your primary goal for your child at our clinic? _____

_____

_____

Prenatal Profile & Birth Experience

▢ Adopted ▢ Prenatal History unknown ▢ Birth history unknown ▢ N/A

		Comment / Description
Complications during pregnancy	N / Y	
Medications during pregnancy (Rx & OTC)	N / Y	
Ultrasounds during pregnancy	N / Y	How many? At how many weeks?
Exposure during pregnancy	N / Y	▢ Alcohol ▢ cigarettes ▢ second hand smoke
during pregnancy, intra-uterine constraining position		N / Unsure ▢ Breech / ▢ Transverse / ▢ Face / ▢ Brow presentation
Location of Birth	▢ Home ▢ Hospital ▢ Birthing Centre	▢ Other:
Meds during labor / delivery (IV/antibiotics)	N / Y	
Was Pitocin used	N / Y	
Birth Attendants	N / Y	▢ Doula ▢ Midwife ▢ GP ▢ OB ▢ Other
membranes ruptured by a medical professional	N / Y	
Length of labor (the 1st regular contractions – birth)		Length of second stage (pushing phase)
Delivery was	▢ Vaginal	Presented: ▢ Head ▢ Face ▢ Breech
	▢ C-section	▢ Planned ▢ Emergency
Interventions	▢ Forceps / ▢ Vacuum extraction	▢ Other
Complications	N / Y	▢ purple markings ▢ bruising on baby's face or head at birth
Concerns about misshapen head at birth	N / Y	

Post Natal & Infant History

Weeks gestation at birth	Wks	Days	Birth weight/length	Lbs:	oz: inches
APGAR scores	1 minute /10		5 minutes /10		
Neonatal Intensive Care	N / Y		how long?/Why?		
meds given at birth	▢ No ▢ Unsure		▢ Yes : what/why?		
Exclusively breastfed	N / Y	Length of time:	mos		
Breastfed + formula fed	N / Y	Length of time:	mos		
Sensitivities to formula	N / Y	▢ reflux ▢ eczema ▢ arching back ▢ frequent spit up			
Age solid foods introduced	N / Y	First foods:			
cereal/grains in 1st year	N / Y				
Attachment parenting	▢ Kangaroo care ▢ Elimination(bowel) communication ▢ Co-sleeping ▢ Feeding on demand ▢ Extended breastfeeding ▢ Other				
Indicate significant time spent in any baby devices	▢ bouncer seats ▢ swings ▢ bumbos ▢ car seats ▢ None ▢ other:				

Supplements

Does your child take: Probiotics? ▢ No ▢ Yes, ____ CFU's/day :: Vitamin D3? ▢ No ▢ Yes, ____ IU's/day

Omega 3 Fish Oils? ▢ No ▢ Yes ____mg/day ▢ Capsule ▢ Liquid :: Other supplements or homeopathics? _____

_____

_____

Do you feel your child is developmentally appropriate for their age:

Intellectually: ▢ Yes ▢ No ::: Emotionally: ▢ Yes ▢ No ::: Physically: ▢ Yes ▢ No

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Symptoms and Health History

Please mark as follows: Current (C) /Previous (P) /Family History (FH)

Acid reflux		Frequent Colds / Croup		Thrush	
ADD / ADHD		Frequent Crying Spells		Tip Toe Walking	
Allergies		Frequent Diarrhea		Tonsillitis	
Allergy shots		Growing Pains		Torticollis / Head Tilt	
Anemia		Mononucleosis		Tremors / Shaking	
Appendicitis		Neck Pain		Ulcers	
Asthma		Night Terrors		Weight Challenges	
Asymmetrical Crawl/Gait		Psychiatric care		Yeast Infections	
Autism / PDD / Spectrum		Rashes		Headaches/Migraines-How often:	
Back Pain		Recurrent Fevers			
Bed Wetting		Red, Swollen, Painful Joint			
Bleeding Disorder		Regression Milestones		Failure to Thrive / Slow Weight Gain	
Chicken Pox		Respiratory Tract Infections			
Colic		Scoliosis		Trouble Feeding on One Side	
Constipation/Flatulence		Seizures			
Diabetes - Type: ▢ 1 ▢ 2		Sinus Problems		Other	
Digestive Problems		Sleep Problems			
Ear Infections		Slow/Absent Reflexes			
Eczema		Strep Throat			

Physical Traumas

Has your child ever…			If YES, Explain
fallen from any high places?	N	Y	
been involved in a motor vehicle accident or near miss?	N	Y	
been seen on an emergency basis?	N	Y	
broken any bones?	N	Y	
had any previous hospitalizations?	N	Y	
had any previous surgeries?	N	Y	

Does your child… (**N**o/**R**arely/Yes)			Yes, Daily/#hrs
frequently use Screens:electronics/TV	N	R	
Exercise / Sports	N	R	Contact sport? N / Y

sleep on their	▢ Back	▢ Belly	▢ Side (▢ both, ▢ right, ▢ left)	
carry a backpack	▢ N/A	▢ No	▢ Yes / Approximate weight of backpack:	lbs
wear their backpack on 2 shoulders	▢ N/A	▢ No	▢ Yes ▢ Sometimes	
show excessive or uneven shoe wear	▢ N/A	▢ No	▢ Yes	
wear custom orthotics	▢ N/A	▢ No	▢ Yes, For what purpose?	

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Chemical Stressors

Gluten	N / Y	▢ Decreasing it in diet ▢ Not sure
dairy	N / Y	▢ Decreasing it in diet
refined sugars (white sugar), white bread and pasta	N / Y	▢ Decreasing in diet ▢ Not sure Most consumed:
boxed/frozen foods	N / Y	
artificial sweeteners	N / Y	▢ Splenda ▢ Aspartame ▢ Diet Soda ▢ Decreasing in diet
other diet restrictions	N / Y	
food/drink allergies, sensitivities, intolerances	N / Y	List:
Antibiotics	N / Y	#rounds in past 6 months: Reason(s): Taken with probiotics: N Y
other meds, including OTC	N / Y	Reason:
Annual flu shots	N / Y	▢ informed decision ▢ recommended by MD
Vaccinations	N / Y	▢ stopped ▢ delayed ▢ selective schedule ▢ on schedule
Reason		▢ Informed decision ▢ Unaware of choice to do so or not ▢ It was recommended
Reaction(s)		▢ Fever ▢ Welt at injection site ▢ Rash ▢ Diarrhea ▢ Fatigue ▢ Prolonged Cry ▢ Seizures / ▢ Developmental Regression ▢ Other:
water/day		▢ 0 ▢ 1-3 ▢ 4-6 ▢ 7-9 ▢10 + (If nursing, please answer for mom's diet)
Non water fluids		▢ 0 ▢ 1-3 ▢ 4-6 ▢ 7-9 ▢ 10 +
Quantity consumed organic		▢ None ▢ Some ▢ All
Second-hand smoke exposure		N / Y – how often: ▢ daily ▢ weekly

I agree that the preceding information is correct and true to the best of my ability to report about the minor child I represent.

Sign_____Print_____Date_____

I am: • Parent/Guardian of: _____

PLEASE VISIT WWW.WELLNESSCHECKONLINE.COM AND FORWARD YOUR CHILD'S RESULTS TO DRPARKER@DRDENISEPARKER.COM

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INFORMED CONSENT AND REQUEST FOR CHIROPRACTIC CARE

As a patient, I have the right to be informed about my health condition(s) and recommended treatments. Dr. Parker or an authorized agent of Resonate Wellness Chiropractic will discuss the potential benefits, risks and hazards involved. After signing this consent form, I understand I can withdraw consent at any time. Chiropractic care is the science, philosophy and art of locating and correcting subluxations (interference) and such, is oriented toward improvement of nervous system function relative to range-of-motion, muscular, and visceral aspects. Basic chiropractic philosophy teaches that subluxation is caused by structural, mental and chemical interference. Because each of those areas causes subluxation, the subluxation is the symptom. It is for this reason other areas are explored outside of the traditional approach to care and is only done so to elicit a response to reveal the subluxation/interference. Although difficult situations may be discussed, it is minimal and only to arrive at the concept to generate a physiological response. It is on no way assumed to be a replacement for professional counseling and/or spiritual guidance. These situations may include talk of emotions and/or spiritual matters as they relate to generating physiology. There are some risks that may be associated with treatment, in particular you should note:

1. While rare, some patients have experienced rib fractures or muscle and ligament sprains or strains following treatment using manual adjustments; There have been rare reported cases of disc injuries following cervical and lumbar spinal adjustment although no scientific study has ever demonstrated such injuries are caused, or may be caused, by spinal or soft tissue manipulation or treatment There have been reported cases of injury to a vertebral artery following osseous spinal manipulation. Vertebral artery injuries have been known to cause a stroke, sometimes with serious neurological impairment and may, on rare occasion, result in paralysis or death. The possibility of such injuries resulting from cervical spine manipulation is extremely remote
2. As with the practice of medicine, the practice of chiropractic is not an exact science, but relies upon information related by the patient, information gathered during examination, and the Doctor's interpretation thereof, as well as the Doctor's judgment and expertise in working with like cases.
3. It is not reasonable to expect my chiropractor to be able to anticipate, or explain, all possible risks and complications of a given procedure on any particular visit and I wish to rely on the Doctor to exercise professional judgment during the course of any procedures, which she feels at the time to be in my best interest.
4. An undesirable result, or side effect, does not necessarily indicate an error in judgment or an improper treatment and may indicate an improved ability to express responses interpreted by my nervous system.

Osseous adjustments and soft tissue manipulations have been the subject of government reports and multi-disciplinary studies conducted over many years and ***have demonstrated it to be highly effective treatment*** of spinal conditions including improvement of:

1. General pain and loss of mobility, headaches and other related symptoms and contributes to your overall wellbeing.
2. The risk of injuries or complications from treatment is substantially lower than that associated with many medical or other treatments, medications, and procedures given for the same symptoms.

_____ I recognize that even the gentlest therapies may potentially have complications in very young children, in the elderly, or in those on multiple medications. Hence, the information I have provided is complete and inclusive of all health concerns and medications, including over-the-counter medications, supplements, and herbs.

_____ I recognize that Dr. Denise Parker is not a counselor or pastor and only draws from personal and professional clinical experience to bring awareness to my system. I also agree to be evaluated further by appropriate professionals outside her training should the need arise or a recommendation is made.

_____ I understand this is a wellness program and likely is not covered by insurance or Medicare. Dr. Parker does not file claims. I agree to request any additional forms necessary for my personal need.

_____ There have been no promises implied or otherwise, of a cure for any symptom, disease or condition as a result of treatment in this clinic. *I have had the opportunity to ask questions and receive answers regarding the treatment.*

I hereby request and consent to the treatments offered or recommended to me for my child by Dr. Denise Parker and Resonate Wellness Chiropractic, including osseous and soft tissue manipulation. I intend this consent to apply to all of my child's present and future care with Dr. Denise Parker and Resonate Wellness Chiropractic.

Sign_____Print_____Date_____

I am: , • Parent/Guardian of: _____

Witness Sign _____ Print _____ Date _____

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CONSENT FOR TRANSMISSION OF PROTECTED HEALTH INFORMATION BY *NON-SECURE MEANS*

We are set up with a HIPAA compliant/encrypted e-mail (drparker@drdeniseparker.com) that protects any information we have within our inboxes. However, once e-mails leave our inbox they are sent by non-secure means. We are also open to exchanging text messages from our office phone. We incorporate security measures to protect the information received to the best of our ability. However, this information is potentially at risk and administrators or technicians may have access to the content of such communications either from our end, or from your own.

Of special consideration are work email addresses. If you use your work email to communicate with us, your employer may access our email communications. There may be similar issues involved in school email or other email accounts associated with organizations that you are affiliated with. Additionally, people with access to your computer, mobile phone, and/or other devices may also have access to your email and/or text messages. Please take a moment to contemplate the risks involved if any of these persons were to access the messages we exchange with each other.

It is your right to receive protected health information via non-secure means, should you consent to authorizing us to do so. If you choose not to provide this authorization, we will restrict communications related to your protected health information to phone calls and in person exchanges.

I, the patient / parent / guardian and undersigned, AUTHORIZE: Resonate Wellness Chiropractic, Dr. Denise Parker & Staff :: 200 N Mill Street :: Lewisville, TX 75057 TO: TRANSMIT THE FOLLOWING **PROTECTED** HEALTH INFORMATION RELATED TO MY HEALTH RECORDS AND HEALTH CARE TREATMENT BY THE FOLLOWING NON-SECURE MEDIA:

- All Health related information transmitted from our office: SECURE email (drparker@drdeniseparker.com)
- SMS text message (i.e. traditional text messaging) or other type of "text message."

Please indicate by initial below:	E-mail	Text
Information related to the scheduling of appointments or other meetings		
Information related to billing and payment (including SuperBills)		
Completed forms, including forms that may contain sensitive, confidential information		
Information of a therapeutic or clinical nature, including discussion of personal material relevant to my treatment		
My health record, in part or in whole, or summaries of material from my health record		

I have been informed of the risks, including but not limited to my confidentiality in treatment, of transmitting my protected health information by unsecured means. I understand that I am not required to sign this agreement in order to receive treatment. **I also understand that I may terminate this authorization at any time** or should I choose to discontinue care.

Sign_____Print_____Date_____

I am: • Parent/Guardian of: _____

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APPOINTMENT POLICY

Our goal is to provide quality individualized wellness care in a timely manner. "No-shows," late shows and cancellations inconvenience those individuals who need access to care in a timely manner. We would like to notify you of our office policy regarding missed appointments. This policy enables us to better utilize available appointments for our patients in need of Dr. Parker's care.

Cancellation of an Appointment
In order to be respectful of the needs of other patients, please be courteous and call Dr. Parker's office promptly if you are unable to show up for an appointment. If it is necessary to cancel your scheduled appointment, we require that you call at least 24 hours in advance. Appointments are in high demand, and your early cancellation will give another person the possibility to have access to timely care.

How to Notify About Changes to Your Appointment
To make changes to your appointment, please **call or text *972-951-9355***. If no one is available to take your call, you may leave a detailed message on the voice mail or opt to send by text message. If you would like to reschedule your appointment, please leave your phone number. **Please note:** while necessary measures are taken to secure information sent via text, it is NOT a secure means of communicating personal health information. Please use caution with your private information when choosing this method of communication.

Late Cancellations: A late cancellation is considered when a patient fails to cancel their scheduled appointment with less than a 24 hour advance notice.

No Show Policy: A "no-show" is someone who misses an appointment without notifying in an adequate manner. A failure to be present at the time of a scheduled appointment will be recorded in the patient's chart as a "no-show." This includes arriving 10 minutes after your scheduled appointment.

Associated Fees:

"No-Show" – 1st time	No Charge
"No-Show" – 2nd time	$50
"No-Show" – 3rd time or more	$100 & Possible discharge
Late Cancellations – 1st/2nd time	No Charge
Late Cancellations – 3rd or more	$50
After hours/weekend/holiday	+$25

I have read and understand this missed appointment policy. Any questions I have regarding this policy have been answered.
Sign_____Print_____Date_____

I am: • Parent/Guardian of: _____