KIDSPACE Adaptive Play and Wellness
469 Buckland Road
South Windsor, 06074
Office: 860.432.9923
Fax: 860.432.7553
www.kidspaceadaptiveplay.com

Welcome!
Thank you for inviting us to participate in your family's healthcare. We hope that this relationship will be helpful as you journey towards improved health. Here at KIDSPACE, we have always functioned as a strong interdisciplinary team dedicated to providing your family with a comprehensive approach to health and wellness. With Jean Makar's experience as a licensed massage and CranioSacral therapist, Karen Peck's advanced training in CranioSacral Therapy and QiGong Massage and the addition of our new chiropractor, Dr. Faraneh, we're formalizing that offering to ensure that all our families, especially our breastfeeding dyads and our "kids" with special needs have accessible and holistic support. Dr. Meila Gruber continues to be available for naturopathic healthcare and holistic treatments for children with neurological and behavioral differences. What does this mean for you? That you may meet with one of us or all of us and have the benefit of our collective and individual experience.

Cost of visits are based on services provided:

New Patient/Initial Consultation	$180
15 Minutes Adjustment, Soft Tissue or Craniosacral Therapy (CST)	$55
30 minutes Adjustment, Soft Tissue, CST &/or Kinesiotaping	$75
New Problem/Reevaluation & Treatment	$100
Tongue Tie Initial Evaluation	$180
Post-Revision Follow Up (exam & minimal treatment)	$55
Post-Revision Follow Up (exam and extensive treatment)	$75
Extensive Phone, Text or Email Consultation	$100/hr
Additional Reports	$50
Pharmacy or other product	Variable
Co-consult w/ Dr. Meila Gruber or Invited Guest	$75-$100
Additional Services	Practitioner's discretion

We have chosen not to participate in any insurance plans. Payment in cash or check is appreciated at the time of service. Upon request, we are able to provide invoices and reports for flex spending reimbursement. Please make checks payable to the individual you scheduled with (Karen Peck, Sharon A. Vallone DC, or Dr. Faraneh). Please speak with us about any financial concerns as soon as they arise.

To schedule an appointment, please call 860.432.9923

ABOUT YOUR CHILD **DATE OF INTAKE**_____

Full Name: _____Birthday (M/D/Y):_____Age: ___

Gender:_____Grade:_____School:_____

Address: _____
(Street) (City) (State) (Postal Code)

Preferred Phone #: _____ cell work home (circle one) Email:_____

Emergency Contact:_____Relationship_____Phone_____

Family Status: M S W D Domestic Partnership Separated Grandparent Guardian Foster Other

Parent/Guardian 1: _____ Preferred Contact:_____ Occupation:_____

Parent/Guardian 2: _____ Preferred Contact:_____ Occupation:_____

Whom may we thank for referring you? _____

Who is your child's pediatrician?(MD or ND) _____

Who was your midwife or OB?_____

REGARDING PREGNANCY AND LABOR

Your age when your baby was born?_____How many pregnancies? _____Live births? _____
Any problems conceiving?_____Treatment?_____
How was your pregnancy overall?_____
During pregnancy were you on medication (over the counter/prescribed)?_____
During pregnancy did you smoke, consume alcohol or take recreational drugs?_____
Was there any pain or problems in pregnancy?_____
Were you physically ill? (colds, flu, allergies, German measles, etc.)_____
Was labor chemically induced?_____Doctor assisted?_____
Approximately how long was labor?_____Who was present?_____
Was a C-section performed?_____Were forceps/vacuum used?_____
Did doctor have hands on the infant?_____What position were you in?_____
Any time in NICU?_____Why?_____How long?_____
What was your baby's gestational age?____Length and weight?_____Head circumference?____
Baby's APGARS:_____1 min_____5 min; Any problems at birth?_____
Did you breastfeed?_____Any problems?_____How long?_____
Did you bottlefeed?_____What formula?_____Any problems?__
Did you see a lactation consultant in hospital?_____Who?_____

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Did you see a lactation consultant privately?_____Who?_____

REGARDING YOUR CHILD'S HEALTH

Has your child ever been hospitalized or had any surgeries?_____

Is your child taking medication? (what, when, and why)_____

_____

Has he/she had any traumas (including birth), injuries or falls?

_____

Has he/she ever been involved in a motor vehicle accident?_____

Has he/she every had any broken bones or sprain injuries?_____

Did your child roll over, sit up, crawl at age appropriate times? Please describe_____

_____

Describe your child in you own words_____

List any questions or concerns, past or present_____

_____

Has your child received standard vaccinations? Reduced Schedule? Please list any reactions

_____

Does your child have any of the following:

_____Allergies	_____Asthma	_____Bedwetting
_____Bloody Noses	_____Frequent Colds	_____Colic
_____Constipation	_____Diarrhea	_____Digestive Problems
_____Ear Problems	_____Fatigue	_____Flu
_____Headaches	_____Hyperactivity	_____Irritability
_____Milk or Lactose Intolerance		_____Learning Disorders
_____Meningitis	_____Nervousness	_____Other
_____Poor posture	_____Rashes	_____Sleeping Disorders
_____Snoring/Apnea		

Has your child had any extensive dental work, extractions or orthodonture?

_____

Does your child have difficulty with food textures, chewing, or swallowing solids or liquids?

_____

Has your child had any of the following illnesses?

_____Measles	_____German Measles	_____Mumps
_____Pneumonia	_____Scarlet Fever	_____Chicken Pox
_____Cancer	_____Rheumatic Fever	_____Urinary Tract Infection
_____RSV	_____Rotavirus	_____Strep Throat
_____HIV/AIDS	_____Tuberculosis	_____Other Illnesses

Please describe your child's habits as good, fair or poor:

Sleeping_____ Eating_____ Listening_____

Mood_____ Physical Strength_____

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If applicable, please place a check next to the skills your child has acquired.

GROSS MOTOR SKILLS:

Able to hold head up momentarily____ Head/shoulder can be supported by forearms____
Infant can be pulled to a sitting position by the hands____ Sits upright unsupported____
Head and shoulder can be supported by the full outstretched arm____
Rolls from lying on their tummy to lying on their back____
Scoots on butt____ Crawls____ Crab crawls____ Drags one leg crawling____
Stands holding on furniture____ Cruises one foot in front of the other____
Runs____ Hops on one foot____ Climbs stairs placing 2 feet on one step____
Climbs stairs placing 1 foot on each step____
Walks down stairs placing 2 feet on one step____
Walks down stairs placing 1 foot on each step____ Other____

FINE MOTOR SKILLS:

Grasps anything put in fist____ Persists in holding hand in a fist____
Bats at objects with an open hand____ Holds and shakes a rattle placed in hand____
Rakes objects with fingers____ Palms objects to pick up and drops them____
Grasps objects independently____ Moves objects from one hand to the other____
Able to self-feed____ Checks objects by placing them in mouth____
Grasps with thumb and index finger____ Turns 2 to 3 pages of a book at a time____
Builds a tower of 5 blocks____ Builds a tower of 10 blocks____

SOCIAL SKILLS:

Plays peek-a-boo____ Reaches for familiar objects____ Plays with hands____
Plays with feet____ Clearly shows joy/pleasure____ Feeds self with fingers____
Smiles____ Understands yes and no ____

COMMUNICATION SKILLS:

Makes cooing sounds____ Cries infrequently ____ Frequently____ Constantly____
Laughs____ Appropriately____ Inappropriately (Why is he/she laughing?)____
Uses one syllable words such as “da”____ Uses 2 syllable words such as “dada”____
Uses 2-3 word vocabulary “me go”____ Uses 2-3 word phrases “me go. want to eat.”____

ADAPTIVE SKILLS:

Holds own bottle or sippy cup____ Feeds from cup unassisted____
Feeds self with utensils____ Able to identify and match colors____
Copies/draws a circle____ Copies/draws a cross____

Please circle any that apply to your child. Fill in extra information if necessary.

Growth, height, or weight problems _____
Difficulty Seeing _____
Difficulty hearing _____
Difficulty speaking or being understood (3+) _____
Does not seem to understand well/slow to “catch on” _____
Clumsy, walks or runs poorly, stumbles (2+) _____
Clumsy with hands _____
Acts younger than age _____
Dependent and “clingy” _____
Passive, seldom shows initiative _____
Disobedient _____
Temper tantrums _____

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Overly aggressive _____
Can't sit still, hyperactive _____
Overly shy, timid, fearful, worries a lot _____
Often seems unhappy _____
Seldom plays with other children _____

FAMILY HISTORY

Please list immediate family members who have been diagnosed with the following.

Autoimmune disease:_____
Diabetes: _____
Stroke: _____
Alcoholism:_____
High Blood Pressure: _____
Fatigue:_____
Bursitis: _____
Cancer:_____
Heart disease: _____
Allergies:_____
Arthritis: _____
Headaches: _____
Back Pains:_____
Other:_____

FOR MOTHERS WHO ARE CURRENTLY BREASTFEEDING

Did you receive antibiotics during pregnancy, labor and delivery, or in the post partum period?
_____

Do you have any sign of a yeast infection? (vaginal discharge, odor, red patches on skin, itchy areas on skin, gas and bloating, foggy thinking, etc.)_____

How was your postpartum healing experience?_____

Did you or are you suffering from postpartum depression?_____

Did you or are you now suffering from thyroid dysfunction?_____

Are you aware of whether you are dealing with inflammatory issues yourself?_____

What is your nutrition like?_____

Do you have any foods you eliminate due to sensitivity or allergy? _____

Do you have a history of breast surgery (reduction or augmentation), breast cancer, poor ductal development, etc._____

How many children have you breastfed?_____

When did your milk come in?_____

How is your milk supply?_____

How is your milk ejection reflex (let down)?_____

Are your nipples painful?_____

Are they damaged? _____

Do your breasts ever feel full?_____

Does your baby empty your breasts?_____

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Do you have plugged ducts (or have you had mastitis)?_____

Are you using herbs or medicine (Reglan or Domperidone) to augment your milk production?
_____

Are you using herbs or medicine to reduce your milk supply?_____

Are you applying anything topically to your breasts?_____

Are you taking an oral antibiotic or antifungal for a breast infection now?_____

Are you pumping at this time?_____

How frequently do you pump?_____For how long (1 or 2 breasts at a time?)_____

Are you pumping to feed your baby or store milk?_____

Are you stressed?_____

Are you sleeping?_____How much and how often?_____

Are you eating and drinking sufficiently to feed two of you?_____

Do you have support at home or are you on your own?_____

When do you return to work?_____

Are you anticipating ending breastfeeding or adjusting baby's schedule to your own?_____

Please list any nursing issues that pertain to your child.

_____Biting	_____Thrusting
_____Falling asleep at breast	_____Nursing on tip of nipple only
_____Nursing constantly	_____Combative nursing
_____Nursing all night	_____ Nursing at night (how many times)

Please circle any of the following programs/services that would be of interest to you:

Support Groups	Parent's Night Out	Educational Workshops
Used Equipment Resources	Birthday Parties	Parental Resource Recommendations

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CONSENT FOR TREATMENT OF A MINOR

I, consent to the treatment/procedure rendered to my child or ward, _____ , under general and specific instructions of my child's health care provider including but not limited to chiropractic, CranioSacral therapy, massage, sensory processing, or art therapy, as well as nutritional and whole health counseling. I have had the mechanisms and risks of chiropractic adjustments based on pediatric anatomy and physiology explained to my satisfaction and authorize said treatment on the above-named child understanding the risks and incidence of deleterious effect. I attest that I am the legal parent/guardian and that I am authorized to make healthcare decisions and consent to healthcare for this child.

_____

Parent/Guardian Signature Date

CONSENT TO PHOTOGRAPH

Photographs of your child help us see changes and help us teach other health care providers about caring for children with similar problems. Due to HIPAA regulations, I will ask permission from you to photograph your child and would like you to check beside each item that you give me consent to use your child's photo for:

Recording progress in the child's chart: ___Yes ___No _____Parent/Guardian Initial
For use in a professional presentation: ___Yes ___No _____Parent/Guardian Initial
For use in a professional publication: ___Yes ___No _____Parent/Guardian Initial

CONSENT TO SHARE INFORMATION WITH ALL PRACTITIONERS AT KIDSPACE

I have been informed that electronic medical records are shared amongst the practitioners at KIDSPACE, I consent to the sharing of my healthcare and education information with the other practitioners at the KIDSPACE facility whether co-treating or consulting.

_____

Signature Date

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS AND/OR PERMISSION TO DISCUSS MEDICAL HISTORY/RECORDS

Patient's Name:_____

CONSENT TO RELEASE MEDICAL RECORDS

I consent to the release of my medical records to:

Name:_____

Address:_____

_____ Phone:_____

Parent/Guardian Signature:_____

Date:_____Relationship to patient, if signed by someone other than patient_____

CONSENT TO DISCUSS MEDICAL HISTORY/RECORDS

I give permission to discuss my medical history/ records with:

Name:_____

Address:_____

_____ Phone:_____

Parent/Guardian Signature:_____

Date:_____Relationship to patient, if signed by someone other than patient_____

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PATIENT RESPONSIBILITIES

I agree to be financially responsible for all charges incurred at this office. I will make payment as required at the time of service. Should collection efforts be necessary to collect money owed, a 15% interest charge will be added to the balance due. I am liable for any cost incurred by the office in collection efforts. **If you are unable to make your appointment, please provide 24 hour notice of cancellation. A cancellation fee will apply for appointments cancelled with less than 24 hour notice.**

_____

Signature Date

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

This document is to be signed by a person legally responsible for the patient's medical decisions relative to the treatment situation.

I, _____, hereby acknowledge that I have been provided with a copy of the Notice of Privacy Practices that describes how medical information about me may be used and disclosed, and how I can access that information. I understand that if I have questions or complaints, I may contact: **Karen Peck CTRS, CST, QST**; **Sharon A. Vallone, DC, FICCP; or Faraneh Carnegie-Hargreaves, DC at 860.432.9923.**

I also understand that I am entitled to receive updates upon request if this office amends or changes its Notice of Privacy Procedures in a material way.

_____

Signature Date

_____

Relationship to Patient, if signed by someone other than the patient.

_____

This section is to be completed by our office, if unable to obtain written acknowledgement from patient.

I made a good faith effort to obtain written acknowledgement of receipt of the Notice of Privacy Practices from the above-named patient, but was unable because:

[ ] Patient declined to sign this written acknowledgement.

[ ] Other (specify):_____

_____

Name and title of employee Date

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SUMMARY OF NOTICE OF PRIVACY PRACTICES

The Notice of Privacy Practices contains a detailed description of how our office will protect your health information, your rights as a patient and our common practices in dealing with patient health information. Please refer to that Notice for further information.

Uses and disclosures of Health Information. We will use and disclose your health information in order to treat you or to assist other health care providers in treating you. We will use and disclose your health information in order help you obtain payment for our services by allowing insurance companies to process insurance claims for services rendered to you by us or by other health care providers. Finally, we may disclose your health information for certain limited operational activities such as assessment, licensing, accreditation, and training of students.

Uses and disclosures based on your authorization. Except as stated in more detail in the Notice of Privacy Practices, we will not use or disclose your health information, social security numbers or other financial information without your written authorization.

Uses and disclosures not requiring your authorization. In the following circumstances, we may disclose your health information without your written authorization.
• To family members or close friends who are involved in your health care.
• For certain limited research purposes.
• For purposes of public health and safety.
• To government agencies for purposes of their audits, investigations and other oversight activities.
• To government authorities to prevent child abuse or domestic violence.
• To the FDA to report product defects or incidents.
• To the law enforcement authorities to protect public safety or to assist in apprehending criminal
offenders.
• When required by court orders, search warrants, subpoenas and as otherwise required by law.

Patient Rights. As our patients you have the following rights:
- To have access to and/or a copy of your health information.
- To receive an accounting of certain disclosures we have made of your health information.
- To request that we communicate with you in confidence.
- To request that we amend your health information.
- To receive a notice of our privacy practices.

A COPY OF THE COMPLETE NOTICE IS AVAILABLE UPON REQUEST.

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