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 & 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 INFANT **DATE OF INTAKE**_____

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

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 midwife or OB?_____

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

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/recreational)?

_____

During pregnancy did you smoke or consume any alcoholic beverages?_____

Was there any pain or problems during 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?____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?_____

Did you see a lactation consultant privately?_____Who?_____

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REGARDING YOUR INFANT'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 infant in your own words_____

List any questions or concerns, past or present_____

_____

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

_____

Does your infant have any of the following?

_____Apnea	_____Colic	_____Constipation
_____Congestion	_____Diarrhea	_____Difficulty Breathing
_____Ear Problems	_____Irritability	_____Rashes
_____Snoring	_____Other	

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

Sleeping_____ Eating_____ Listening_____

Mood_____ Physical Strength_____

Has your infant 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

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____

FINE MOTOR SKILLS:

Grasps anything put in fist____
Bats at objects with an open hand____
Rakes objects with fingers____
Grasps objects independently____
Persists in holding hand in a fist____
Holds and shakes a rattle placed in hand____
Palms objects to pick up and drops them____
Moves objects from one hand to the other____

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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 _____
Dependent and "clingy" _____

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?_____

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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?_____

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?_____

Do you have any other important history of medical conditions (heart, lung, cancer, thyroid, etc) or history of injury, surgery, past chiropractic care:_____

_____

FOR INFANTS WHO ARE CURRENTLY BREASTFEEDING

Check or fill in the blank for each item that applies to you and your infant:

_____ Long breastfeeding times (How long? _____)
_____Frequent breaks in feeding
_____Falling asleep at the breast
_____Unable to latch onto the breast at all
_____Thrusting
_____Nursing on tip of nipple only
_____Nursing constantly
_____Combative nursing
_____Unable to latch onto the breast well

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_____Baby cannot open their mouth widely
_____The baby clamps or bites
_____Upper lip does not flare out (to make proper passive seal)
_____Lips have cobble stone appearance (as they actively seal)
_____Excessive gas, burp, wind, hiccups (due to poor seal) – (circle all that apply)
_____Nursing at night (how many times) Milk spilling out of the mouth
_____Baby choking on the milk
_____Baby has difficulty sleeping and wakes frequently to feed
_____Clicking noise during feed?
_____Unable to stick the tongue out past the gum.
_____Unable to stick the tongue out past the lower lip.
_____Reduced elevation of the tongue (can the tongue lift up and touch the roof of the mouth).
_____Heart shaped tongue when baby lifts tongue or sticks tongue out (elevation & extension)
_____Sweeping your finger under the tongue reveals a "speed bump" or obstruction (tie).
_____Heredity: history of lip tie or tongue tie
Siblings_____Parents _____Grandparents_____
_____Failure to gain weight or slow to gain weight
Birth weight _____Loss from birth weight _____ Current weight _____

How many wet diapers a day?_____ How many stools a day? _____Color, texture, smell, seeds of the stool?_____
Any mucous or blood in the stool? _____
Breast milk production issues (circle one):Oversupply or Undersupply _____
Breast pain (circle one): very high high medium low very low none
On first latch but improves with time consistently through feed
Breast damage (circle all that apply):
cracking bleeding yeast or bacterial infection blocked ducts (plugs)
Medication or ointments applied to breasts: _____
Oral antibiotics or antifungals (indicate mom or baby): _____
Supplementation: bottle_____SNS_____finger fed_____other_____

- Pumped breast milk (your own):_____# of oz_____
- Formula (type) _____# of oz_____
- Donated breast milk _____# of oz_____

How many times is the baby at breast and how many times is the baby supplemented as noted above?_____
Overall latch quality (circle one):
No problems
Minor issues
Several problems
Breast damage
Supplementing with bottle or baby will not gain weight
Baby cannot latch at all

Any additional information:_____

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FAMILY HISTORY

Please list immediate family members who have the following conditions:

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

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 health care and education information with the other practitioners at the KIDSPACE facility whether co-treating or consulting.

_____

Signature Date

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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 Drs. Sharon A. Vallone or Faraneh Carnegie-Hargreaves 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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