Child Health Questionnaire
for Dr. Sam Yanuck

(to be filled out by the parent(s) - if your child is old enough to fill this out, please use the adult questionnaire)

Full Name____________________________ Parent 1 ____________________________

Address____________________________ Parent 2 ____________________________

City____________State_____Zip______ Emergency Contact ________________________

Date of birth ____/____/____ Sex _________ Relationship to child __________ Phone __________

Parent's phones: (cell 1) __________ (cell 2) __________ (email 1 / 2) __________________

Whom may we thank for referring you? ________________ Relationship to you ________________

I, ________________________, have read and understand Dr. Yanuck's office policy sheet. I understand that I am personally responsible for payment at the time when services are rendered.

Signature____________________________________ Date__________________

Primary Concern

What is your child's primary health problem?____________________________________

____

Date of original problem:________________ Date of most recent recurrence:________________

Was there an event that created the problem?____________________________________

Have your child had this or similar conditions in the past? _______ Is the problem getting worse? ____________

What makes it better?________________________ Worse?________________________

Is this problem interfering with school?________Sleep?________Activity?______Other?________

What can your child not do now that he/she would like to do? ____________________________

What are your goals for your child's treatment? ____________________________________

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Health History

List all other **CURRENT** problems **<u>in their order of importance</u>** ____

____

____

____

List other practitioners seen, treatments, self care activities, and results____

____

____

____

____

Has your child ever seen a chiropractor? No Yes (Name: _____________________ Result: _________________________)

Does your child have any spinal abnormalities that you are aware of? ____

List **ALL** significant PAST illnesses ____

____

____

Please list **ALL** chronic infections (Epstein barr, herpes, chlamydia, hepatitis, HIV, bladder infections, respiratory infections, etc.)

____

List **ALL** surgeries your child has had, with dates and results ____

____

Has your child ever been hospitalized other than for surgery?____

Has your child ever been in an accident or seriously injured? List dates and describe______________________________

____

<u>Has your child ever had:</u> whiplash? Yes___ No___ // a hard fall on the tailbone? Yes___ No___ // a seizure? Yes___ No___

Describe your child's worst injury ever, and any long lasting effects it has had on his/her health __________________________

____

Describe any travel related illnesses ____

Is there a time in your child's life when he or she began feeling significantly less healthy? Yes _____ No _____ If yes, please describe… ____

How many root canals does your child have? _________ How many doses of antibiotics (total <u>lifetime)</u>? ___________

How many times **per month** does your child take aspirin? ____ Ibuprofen? ____ Tylenol? ____ Antacids? ____ Laxatives? _____

For what purpose are these taken? ____

Family History

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Have any of your child's blood relatives (parents, brothers, sisters, aunts, uncles, grandparents), living or deceased, had any of the following problems? ***For each YES***, state the age of the person when the problem occurred and their relationship with your child.

Condition	**Yes**	**No**	**Age**	**Relationship**
Alcoholism / Drug Addiction	__	__	_____	____________________
Allergies / Asthma	__	__	_____	____________________
Arthritis	__	__	_____	____________________
Blood disorders	__	__	_____	____________________
Cancer (type ________________________)	__	__	_____	____________________
Diabetes	__	__	_____	____________________
Digestive Disorders (type ______________)	__	__	_____	____________________
Heart attack before age 55	__	__	_____	____________________
Heart attack after age 55	__	__	_____	____________________
High blood pressure	__	__	_____	____________________
Kidney or Liver disease	__	__	_____	____________________
Lung disease / tuberculosis	__	__	_____	____________________
Mental health problems/ depression	__	__	_____	____________________
Seizure Disorder	__	__	_____	____________________
Stroke	__	__	_____	____________________
Thyroid disease	__	__	_____	____________________
Uterine / Ovarian problems	__	__	_____	____________________

List other problems that run in your family ____

Habits

Describe your child's exercise habits (activity / times per week) ________________________________

Describe your child's current sleeping pattern (bedtime, waking time, napping, difficulty with sleep) ____________________

____

Does your child have enough energy for normal activities? Yes____ No____ How long does your child watch TV each day?_____

What does your child do for fun / pleasure / relaxation? ____

Preventive Measures and Screening

When did your child last receive the following (leave blank if it does not apply). Circle the test if you've had an abnormal result

General physical exam______________ CBC/chemistry______________________

Dental exam_____________________ Eye exam______________________ Hearing test_________________________

Other tests/scans (describe) ____

Has your child ever had an X-RAY, MRI or CT (CAT) scan? Yes____ NO____ If so, what for?___________________________

Has your child received the following vaccines:

Tetanus/Diptheria (Td)____ Flu____ Pneumonia____ Polio____ Measles/Mumps/Rubella____ Hepatitis B ____ Other_______

Allergies and Sensitivities

Please list any allergies you are aware of (**foods / medications / other**): ____

Please list any chemical sensitivities you are aware of: (bleach, solvents, perfumes, etc.) _________________________________

Is your child particularly sensitive to the effects of medications? Yes _____ No _____

Has your child ever reacted to a medication in an unexpected way? Yes ___ No ___ If yes, please describe ___________________

Has your child had problems with damp or moldy places? Yes ___ No ___ Problems with new building materials? Yes ___ No ___

Nutrition

What does your child usually eat and drink on a typical weekday?

Breakfast ____

Morning snack ____

Lunch ____

Afternoon snack ____

Dinner ____

Evening snacks ____

Desserts ____

How many glasses of water per day? ______ **Circle** those that apply: tap water, distilled, bottled, well-water, other

How many servings per day of the following: Fruits & Vegetables___ Coffee___ Tea____ Soda___ Diet Soda___

If your child takes nutritional supplements, is there a specific improvement in the way he/she functions?______________________

How many meals each week are:

At home_______ Alone_______ In restaurant_______ At fast food place_______ TV Dinners or "convenience" food ________

While watching TV_____ From deli______ At "health food" restaurant or takeout ___________

Does your child eat if he/she is not hungry but feels depressed, anxious or bored? Frequently / Occasionally / Rarely / Never (circle)

Does your child ever: **a)** binge eat? Yes__ No__ **b)** sneak or hide foods? Yes__ No__ **c)** make him/herself vomit? Yes __ No __
d) eat slowly and chew his/her food well? Yes __ No __ **e)** use extra salt on food at the table? Yes __ No __

List the oils or fats you use in cooking/preparing food: ____

Does your child enjoy eating cheese? Yes____ No____ Drinking milk? Yes____ No____ If so, how much per day? __________

Does your child like sweets, pastries, cakes, donuts, etc.? Yes___ No___ How many servings per week? _______

Does your child eat sugarcoated cereal or add sugar to cereal? Yes___ No__ How many servings per week? _______

Does your child use artificial sweeteners (in diet soda or other foods)? Yes___ No___ How many servings per week? _______

When your child eats bread, is it white or whole wheat?_______ After eating, does he/she feel: Better / Worse / No different (circle)

Does your child usually eat breakfast? Yes__ No__ Does your child feel better if he/she skips breakfast? Yes____ No____

Does your child snack between meals? Yes__ No__ Does your child frequently skip meals? Yes ______ No ____

What is your child's preferred snack food? ____

Is there one food that your child likes the most, eats a lot of, and craves when he/she doesn't have it? _________________________

Does your child have any reaction to eating food with MSG in it? Yes__ No__ If so, please describe: _________________________

Does your child have trouble with gaining weight too easily?……...…Yes____________ No ________

Does your child have trouble with losing weight too easily? ....……Yes____________ No ________

If your child's weight has changed, please describe the circumstances involved ____

Does your child have more than one meal a day that lacks a vegetable other than corn, potatoes, peas or beans? Yes______No_____

Are there days when your child does not eat any raw vegetables? .... Yes____________ No_______

List the three healthiest foods your child eats in the average week: __________________, _________________, _______________

List the three un-healthiest foods your child eats in the average week: __________________, _________________, _____________

Are there specific foods that irritate your child in any way? Yes ___ No ___ If yes, name the foods and describe the problem:

____

Please describe any ways in which you feel your child's diet is excessive: ____

____

Please describe any ways in which you feel your child's diet is deficient: ____

____

List all vitamins, herbs and other supplements your child is now taking ____

____

____

Metabolic Assessment

Please CIRCLE the appropriate number on all questions. 0 = lease/never. 3 = most/always.

Category I - C

Symptom	Rating
Feeling that bowels don't empty completely	0 1 2 3
Lower abdomen pain relief passing stool or gas	0 1 2 3
Alternating constipation and diarrhea	0 1 2 3
Diarrhea	0 1 2 3
Constipation	0 1 2 3
Hard, dry, or small stool	0 1 2 3
Coated tongue or "fuzzy" debris on tongue	0 1 2 3
Pass large amount of foul smelling gas	0 1 2 3
More than 3 bowel movements daily	0 1 2 3
Use laxatives frequently (more than twice a month)	0 1 2 3

Category II - P

Symptom	Rating
Increasing frequency of food reactions	0 1 2 3
Unpredictable food reactions	0 1 2 3
Aches, pains, and swelling throughout the body	0 1 2 3
Unpredictable abdominal swelling	0 1 2 3
Frequent bloating and distention after eating	0 1 2 3
Abdominal intolerance to sugars and starches	0 1 2 3

Category III - Chem

Symptom	Rating
Intolerance to smells	0 1 2 3
Intolerance to jewelry	0 1 2 3
Intolerance to shampoo, lotion, detergents, etc.	0 1 2 3
Multiple smell and chemical sensitivities	0 1 2 3
Constant skin outbreaks	0 1 2 3

Category IV – HCL -

Symptom	Rating
Excessive belching, burping, or bloating	0 1 2 3
Gas immediately following a meal	0 1 2 3
Offensive breath	0 1 2 3
Difficult bowel movements	0 1 2 3
Sense of fullness during and after meals	0 1 2 3
Difficulty digesting fruits and vegetables; Undigested food visible in stool	0 1 2 3

Category V – HCL +

Symptom	Rating
Stomach pain, burning, or ache1-4 hours after eating	0 1 2 3
Use antacids	0 1 2 3
Feel hungry an hour or two after eating	0 1 2 3
Heartburn when lying down or bending forward	0 1 2 3
Temporary relief from antacids, food, milk, carbonated beverages	0 1 2 3
Digestive problems subside with rest and relaxation	0 1 2 3
Heartburn due to spicy foods, chocolate, citrus, peppers, alcohol, and caffeine	0 1 2 3

Category VI - SI

Symptom	Rating
Roughage and fiber cause constipation	0 1 2 3
Indigestion and fullness lasts 2-4 hours after eating	0 1 2 3
Pain, tenderness, soreness on left side under rib cage	0 1 2 3
Excessive passage of gas	0 1 2 3
Nausea and/or vomiting	0 1 2 3
Stool undigested, foul smelling, mucous-like, greasy, or poorly formed	0 1 2 3
Frequent urination	0 1 2 3
Increased thirst and / or appetite	0 1 2 3
Difficulty losing weight	0 1 2 3

Category VII - GB

Symptom	Rating
Greasy or high-fat foods cause distress	0 1 2 3
Lower bowel gas and/or bloating hours after eating	0 1 2 3
Bitter metallic taste in mouth, especially in the morning	0 1 2 3
Unexplained itchy skin	0 1 2 3
Yellowish cast to eyes	0 1 2 3
Stool color alternates from clay colored to normal	0 1 2 3
Reddened skin, especially palms	0 1 2 3
Dry or flaky skin and / or hair	0 1 2 3
History of gallbladder attacks or stones	0 1 2 3
Have you had your gallbladder removed	Yes No

Category VIII - LV

Symptom	Rating
Acne and unhealthy skin	0 1 2 3
Excessive hair loss	0 1 2 3
Overall sense of bloating	0 1 2 3
Bodily swelling for no reason	0 1 2 3
Hormone imbalances	0 1 2 3
Weight gain	0 1 2 3
Poor bowel function	0 1 2 3
Excessively foul-smelling sweat	0 1 2 3

Category IX - HG

Symptom	Rating
Crave sweets during the day	0 1 2 3
Irritable if meals are missed	0 1 2 3
Depend on caffeine to get started or keep going	0 1 2 3
Get light headed if meals are missed	0 1 2 3
Eating relieves fatigue	0 1 2 3
Feel shaky, jittery, or have tremors	0 1 2 3
Agitated, easily upset, nervous	0 1 2 3
Poor memory / forgetful	0 1 2 3
Blurred vision	0 1 2 3

Category X - IR

Symptom	Rating
Fatigue after meals	0 1 2 3
Crave sweets during the day	0 1 2 3
Eating sweets does not relieve craving for sugar	0 1 2 3
Must have sweets after meals	0 1 2 3
Waist girth is equal or larger than hip girth	0 1 2 3
Frequent urination	0 1 2 3
Increased thirst and appetite	0 1 2 3
Difficulty losing weight	0 1 2 3

Category XI – A-

Symptom	Rating
Cannot stay asleep at night	0 1 2 3
Crave salt	0 1 2 3
Slow starter in the morning	0 1 2 3
Afternoon fatigue	0 1 2 3
Dizziness when standing up quickly	0 1 2 3
Afternoon headaches	0 1 2 3
Headaches with exertion or stress	0 1 2 3
Weak nails	0 1 2 3

Category XII – A+

Symptom	Rating
Cannot fall asleep	0 1 2 3
Perspire Easily	0 1 2 3
Under high amount of stress	0 1 2 3
Weight gain when under stress	0 1 2 3
Wake up tired even after 6 or more hours of sleep	0 1 2 3
Perspire excessively or with little activity	0 1 2 3

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Metabolic Assessment

Please CIRCLE the appropriate number on all questions. 0 = lease/never. 3 = most/always.

Category XIII - pH

Symptom	Rating
Edema and swelling in ankles and wrists	0 1 2 3
Muscle cramping	0 1 2 3
Poor muscle endurance	0 1 2 3
Frequent urination	0 1 2 3
Crave salt	0 1 2 3
Abnormal sweating from minimal activity	0 1 2 3
Alteration in bowel integrity	0 1 2 3
Inability to hold breath for long periods	0 1 2 3
Shallow, rapid breathing	0 1 2 3

Category XIV – T-

Symptom	Rating
Tired, sluggish	0 1 2 3
Feel cold – hands, feet, all over	0 1 2 3
Require lots of sleep to function properly	0 1 2 3
Increase in weight gain even with low-calorie diet	0 1 2 3
Gain weight easily	0 1 2 3
Difficult, infrequent bowel movements	0 1 2 3
Depression, lack of motivation	0 1 2 3
Morning headaches that wear off during the day	0 1 2 3
Outer third of the eyebrow thins	0 1 2 3
Thinning of hair on scalp, face, or genitals or Excessive falling hair	0 1 2 3
Dryness of skin and / or scalp	0 1 2 3
Mental Sluggishness	0 1 2 3

Category XV – T+

Symptom	Rating
Heart palpitations	0 1 2 3
Inward trembling	0 1 2 3
Increased pulse even at rest	0 1 2 3
Nervous and emotional	0 1 2 3
Insomnia	0 1 2 3
Night sweats	0 1 2 3
Difficulty gaining weight	0 1 2 3

Category XVI – P-

Symptom	Rating
Diminished sex drive	0 1 2 3
Menstrual disorders or lack of menstruation	0 1 2 3
Increased ability to eat sugars without symptoms	0 1 2 3

Category XVII – P+

Symptom	Rating
Increased sex drive	0 1 2 3
Reduced tolerance sugars	0 1 2 3
“Splitting” type headaches	0 1 2 3

Category XVIII (Males Only)

Symptom	Rating
Urination difficulty or dribbling	0 1 2 3
Frequent urination	0 1 2 3
Pain inside of legs or heels	0 1 2 3
Feeling of incomplete bowel evacuation	0 1 2 3
Leg nervousness at night	0 1 2 3

Category XIX (Males Only)

Symptom	Rating
Decreased libido	0 1 2 3
Decrease in spontaneous morning erections.	0 1 2 3
Decrease in fullness of erections	0 1 2 3
Difficulty in maintaining morning erections	0 1 2 3
Spells of mental fatigue	0 1 2 3
Inability to concentrate	0 1 2 3
Episodes of depression	0 1 2 3
Muscle soreness	0 1 2 3
Decrease in physical stamina	0 1 2 3
Unexplained weight gain	0 1 2 3
Increase in fat distribution around chest and hips	0 1 2 3
Sweating attacks	0 1 2 3
More emotional than in the past	0 1 2 3

Category XX (Menstruating Females Only)

Symptom	Rating
Are you perimenopausal (going through the transition into menopause)	Yes No
Alternating menstrual cycle lengths	Yes No
Extended menstrual cycle, greater than 32 days	Yes No
Shortened menses, less than every 24 days	Yes No
Pain and cramping during periods	0 1 2 3
Scanty menstrual flow	0 1 2 3
Heavy menstrual flow	0 1 2 3
Breast pain and swelling during menses	0 1 2 3
Pelvic pain during menses	0 1 2 3
Irritable and depressed during menses	0 1 2 3
Acne breakouts	0 1 2 3
Facial hair growth	0 1 2 3
Hair loss / thinning	0 1 2 3

Category XXI (Menopausal Females Only)

Symptom	Rating
How many years have you been menopausal	____________
Hot flashes	0 1 2 3
Disinterest in sex	0 1 2 3
Depression	0 1 2 3
Shrinking breasts	0 1 2 3
Acne	0 1 2 3
Since menopause, do you ever have bleeding?	Yes No
Mental fogginess	0 1 2 3
Mood swings	0 1 2 3
Painful intercourse	0 1 2 3
Facial hair growth	0 1 2 3
Increased vaginal pain, dryness or itching	0 1 2 3

Please answer all that apply (Females Only):

Age at which you first had symptoms of perimenopause (transition from normal menstruation to menopause): _________

Did you / do you have significant symptoms during perimenopause?_____If yes, please describe: ___________________________

Number of pregnancies________Number of deliveries__________Difficulties with child birth ____________________________

Birth control method you are using currently___________________Have you ever used an IUD? _______________________

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Symptom Survey

Please *check the appropriate boxes :* → → → C = Current P = Past

C P Headache

- ☐ ☐ Base of Skull
- ☐ ☐ Entire Head
- ☐ ☐ Forehead
- ☐ ☐ Top of Head
- ☐ ☐ Temples
- ☐ ☐ Throbbing
- ☐ ☐ Migraine
- ☐ ☐ Visual Disturbance
- ☐ ☐ Vomiting
- ☐ ☐ Dizziness
- ☐ ☐ Double Vision
- ☐ ☐ Lightheaded
- ☐ ☐ Ringing in Ears

C P Neck

- ☐ ☐ Grinding Noise
- ☐ ☐ Head Feels Heavy
- ☐ ☐ Sharp Pain
- ☐ ☐ Dull Ache
- ☐ ☐ Stiffness
- ☐ ☐ Goiter
- ☐ ☐ Lumps in Neck
- ☐ ☐ Swollen Glands

C P Arms / Hands

- ☐ ☐ Arms "fall asleep"
- ☐ ☐ Arm pain L R
- ☐ ☐ Wrist pain L R
- ☐ ☐ Hand pain L R
- ☐ ☐ Muscles twitch L R
- ☐ ☐ Loss of grip L R

C P Mid-Back

- ☐ ☐ Ache
- ☐ ☐ Sharp pain
- ☐ ☐ Breathing hurts
- ☐ ☐ stiff

C P Shoulders

- ☐ ☐ Shoulder Bursitis L R
- ☐ ☐ Can't raise arm L R
- ☐ ☐ Rotator cuff L R
- ☐ ☐ Ache L R
- ☐ ☐ Sharp pain L R
- ☐ ☐ Ache into neck L R
- ☐ ☐ Stiff L R

C P Low Back / Hips / Legs

- ☐ ☐ Cold feet
- ☐ ☐ Legs fall asleep
- ☐ ☐ Legs restless at night
- ☐ ☐ Leg muscles twitch
- ☐ ☐ Leg pain L R
- ☐ ☐ hip pain L R
- ☐ ☐ ankle pain L R
- ☐ ☐ Unstable ankle L R
- ☐ ☐ Unstable knee L R
- ☐ ☐ Unstable hip L R
- ☐ ☐ Leg cramps with walking
- ☐ ☐ Legs cramp at night
- ☐ ☐ Hip bursitis

C P Muscles and Joints

- ☐ ☐ TMJ (Jaw problems)
- ☐ ☐ Osteoarthritis
- ☐ ☐ Degenerative joints
- ☐ ☐ Rheumatoid arthritis
- ☐ ☐ Gout
- ☐ ☐ Swollen joints
- ☐ ☐ Tendinitis
- ☐ ☐ Muscle aches
- ☐ ☐ Eyelids or other facial muscles twitch

C P Low Back Pain with:

- ☐ ☐ Bending
- ☐ ☐ Cough / sneeze
- ☐ ☐ Lifting
- ☐ ☐ Sitting
- ☐ ☐ Standing
- ☐ ☐ Twisting
- ☐ ☐ Driving
- ☐ ☐ Sleeping

Please list areas where you have any numbness or swelling

____

____

____

C P Psychological

- ☐ ☐ Anxiety
- ☐ ☐ Bipolar disorder
- ☐ ☐ Depression
- ☐ ☐ Insomnia/difficult sleep
- ☐ ☐ Irritability
- ☐ ☐ Brain Fog
- ☐ ☐ Mental Disorganization
- ☐ ☐ Nervousness
- ☐ ☐ Poor memory
- ☐ ☐ Suicidal ideas
- ☐ ☐ Violent thoughts

C P Cardiac

- ☐ ☐ Arrhythmia
- ☐ ☐ Chest pain
- ☐ ☐ Chest tightness
- ☐ ☐ Heart attack
- ☐ ☐ Heart murmur
- ☐ ☐ High blood pressure
- ☐ ☐ High cholesterol
- ☐ ☐ Palpitations
- ☐ ☐ Racing heartbeat
- ☐ ☐ Rheumatic fever
- ☐ ☐ Shortness of breath
- ☐ ☐ Swelling in feet
- ☐ ☐ Trouble breathing

C P Respiratory

- ☐ ☐ Asthma
- ☐ ☐ Bronchitis
- ☐ ☐ Cough
- ☐ ☐ Emphysema
- ☐ ☐ Pneumonia
- ☐ ☐ Sputum
- ☐ ☐ Tuberculosis
- ☐ ☐ Wheezing

C P Peripheral Vascular

- ☐ ☐ Blood clots
- ☐ ☐ Bruise easily
- ☐ ☐ Leg cramps
- ☐ ☐ Poor circulation
- ☐ ☐ Varicose veins

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Patient Medication List

Your Name____Date __________________

Please describe each of your medications clearly. If a medication is giving you specific side effects, list them. Dr. Yanuck will fill in the "nutrient depletion" sections.

Drug__________________Prescribed by________________Dose________Started_______Planned End Date ______

Purpose for Taking_______________________________________Is it working? _____________________________

Side Effects ____ Nutrient Depletion ___________________________

Drug__________________Prescribed by________________Dose________Started_______Planned End Date ______

Purpose for Taking_______________________________________Is it working? _____________________________

Side Effects ____ Nutrient Depletion ___________________________

Drug__________________Prescribed by________________Dose________Started_______Planned End Date ______

Purpose for Taking_______________________________________Is it working? _____________________________

Side Effects ____ Nutrient Depletion ___________________________

Drug__________________Prescribed by________________Dose________Started_______Planned End Date ______

Purpose for Taking_______________________________________Is it working? _____________________________

Side Effects ____ Nutrient Depletion ___________________________

Drug__________________Prescribed by________________Dose________Started_______Planned End Date ______

Purpose for Taking_______________________________________Is it working? _____________________________

Side Effects ____ Nutrient Depletion ___________________________

Please list medications you have taken in the past: ____

____

I____understand that any changes to my regimen of medications must be made in coordination with and under the instructions of the physician who prescribed them.

Signed____Date ___________________

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Pain Questionnaire

(Skip to the next page if your child is not currently experiencing pain.)

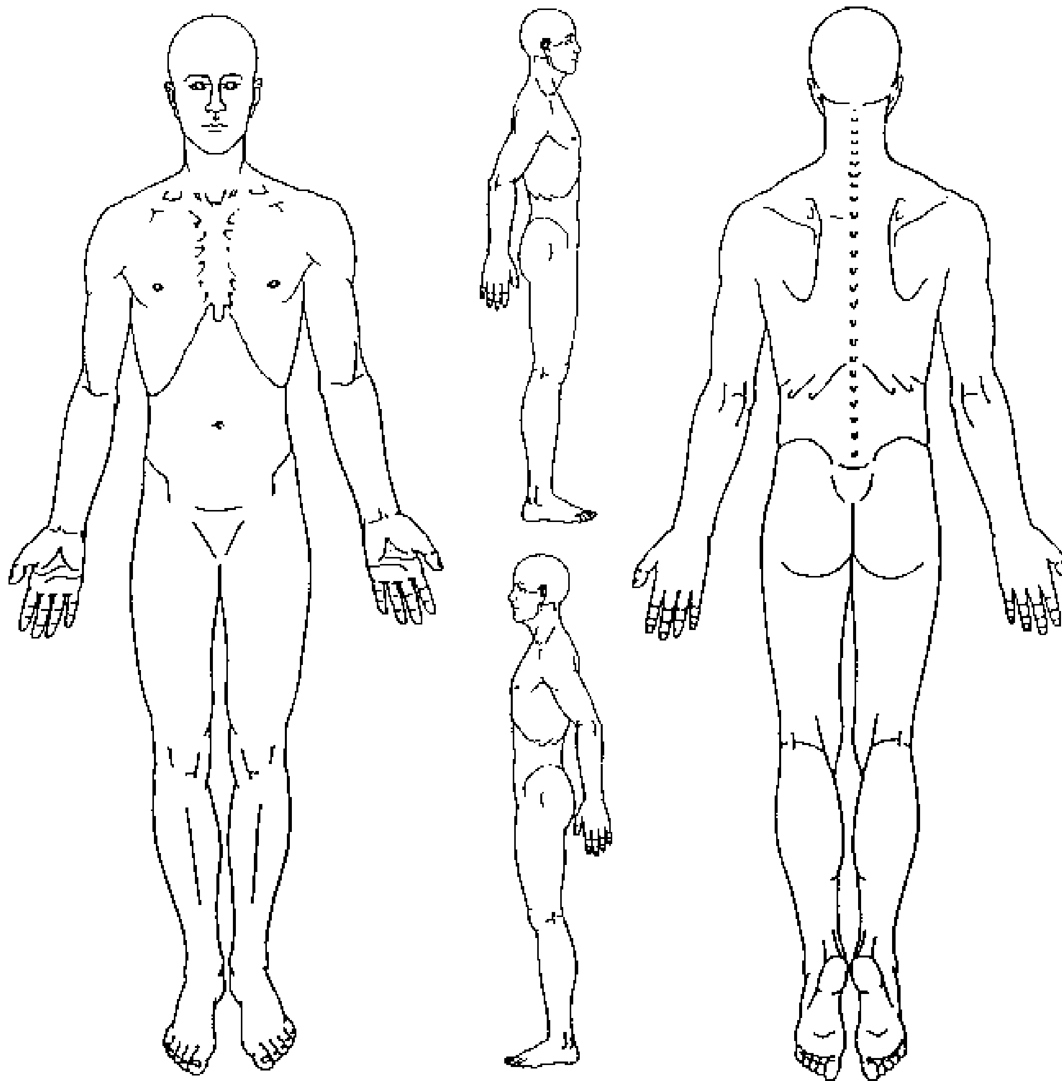
Name______________________________________

Please place a single vertical line through the scale below at the point that best describes your pain.
(0 is no pain, 10 is the worst pain imaginable)

0.........|.........|.........|.........|.........|.........|.........|.........|.........|.........10

Mark the areas on your body where you feel the following sensations.
Use the appropriate symbol. Include all affected areas.

Ache ^ ^ ^ ^ ^ ^	Burning x x x x x x x x	Numbness --- --- --- --- --- ---
Pins & Needles o o o o o o	Stabbing / / / / / / / /	Throbbing T T T T T T



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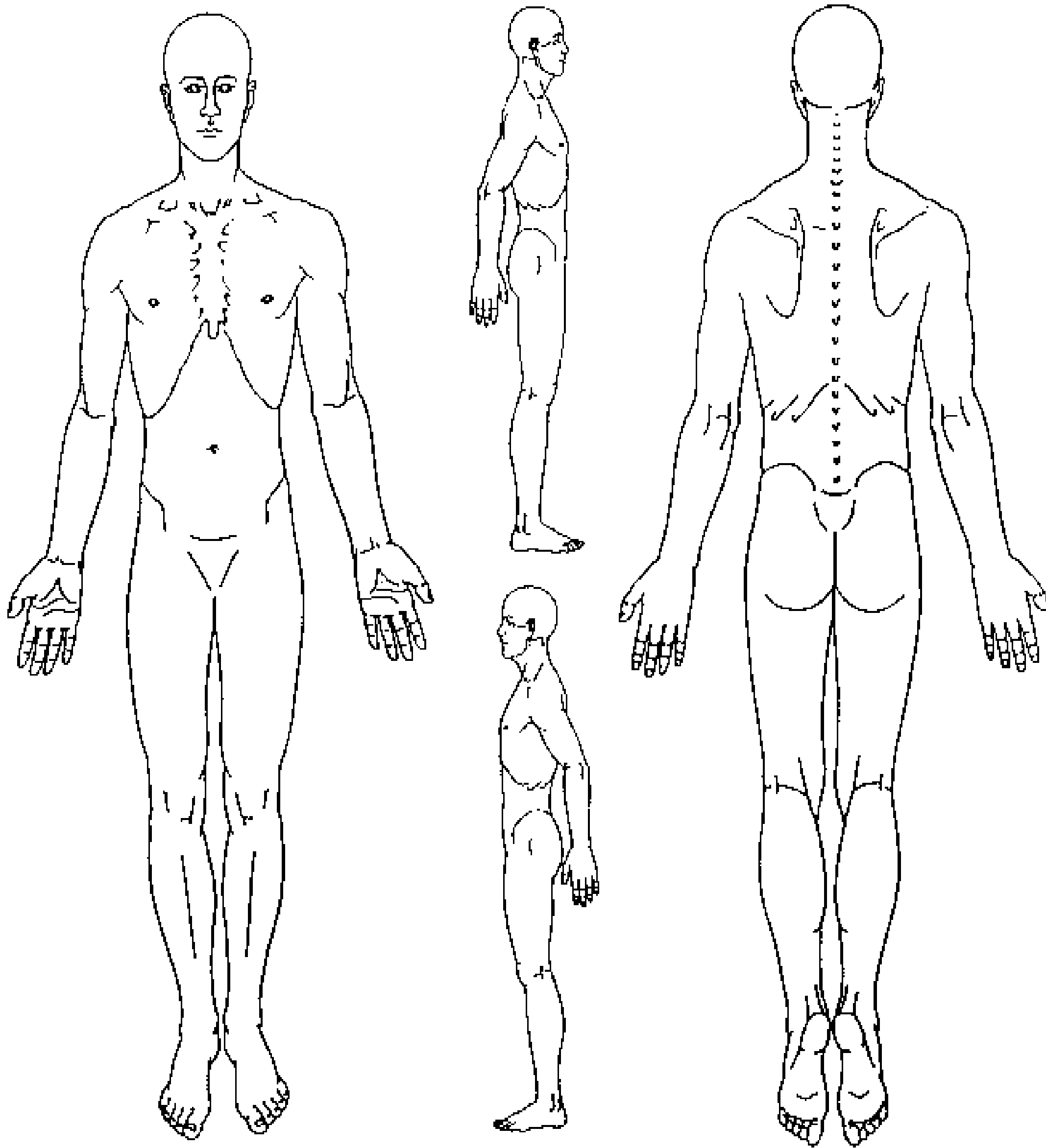
History of Injury

Name ____

Please mark with an "X" all the places where your child has ever been injured (sprains, strains, burns, broken bones, scars from surgeries or accidents, severe bruises, concussions, hard blows to the head, falls, etc.).

Be sure to note any organs that have been operated on or removed. (tonsils, wisdom teeth, appendix, etc.).



Cheryl H.Yanuck, MD
A Professional Corporation
Tel: 919/493-0406
Fax: 919/401-9900

The Yanuck Center
for Life and Health
www.YanuckCenter.com
329 Providence Road
Chapel Hill, NC 27514

Samuel F. Yanuck, DC, FACFN, FIAMA
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About Medications

The treatment that Dr. Yanuck provides is intended to improve all aspects of your child's health. As your child's care progresses, his/her body may be better able to heal itself in all respects. Because of this, your child's cognitive functions, allergic responses, blood sugar levels, and other important bodily functions may improve. If this occurs, it is possible that the doses of medications your child is taking will have to be modified, to account for this improvement. It is your responsibility to monitor or have monitored those of your child's functions that relate to medications he or she is currently taking, to ensure that current doses do not become excessive or deficient in their effect on your child. These and any other any changes to your child's regimen of medications must be made in coordination with and under the instructions of the physician who prescribed them.

All nutritional supplements should always be discontinued 10 days prior to any surgery and restarted with guidance from both Dr. Yanuck and the surgeon involved.

Additional Information

Please arrange to have any other relevant information sent to our office. This might include medical records, lab results, consultation reports, and any other test or study results such as x-rays or CT scans. This will help Dr. Yanuck evaluate your child's condition. Short documents like lab results or MRI reports may be faxed to (919) 401-9900. Longer documents like overall patient records should be copied and sent to the office.

Please list the names of your child's pediatrician and other doctors, so Dr. Yanuck can send a report to them with the details of his findings in your child's case, should it become appropriate for him to do so. List each doctor's full name and as much of the address information as you know.

____________________________________ ____________________________________

____________________________________ ____________________________________

____________________________________ ____________________________________

☐ Please check this box if you wish to give Dr. Yanuck permission to send a report of his impressions to the doctors listed above, and give Dr. Yanuck and the doctors listed above permission to discuss your child's case.

As parent/guardian, I ____________________________ hereby authorize the treatment of ___________________________ by Dr. Samuel F. Yanuck, chiropractic physician. I understand that I will be responsible for supervising all aspects of care, including follow up, home instructions, and any other needs that might arise.

Signature____ Date___________________

Relationship to the patient ____________________________________

THE YANUCK CENTER
for Life and Health

Authorization For And Consent To Treatment

This clinic maintains personnel and facilities to assist your doctor in the performance of various manipulative procedures and other diagnostic and therapeutic procedures. These manipulative and ancillary procedures all may involve calculated risks or complications, injury or even death, from both known and unknown causes and no warranty or guarantee has been made as to the result or cure. Except in emergency or exceptional circumstances, procedures are not performed upon patients unless and until the patient has had an opportunity to discuss them with the doctor.

Each patient has the right to refuse any proposed procedure, process, or therapy, at any time during each visit.

Due to the uniqueness of each case and each individual, including his or her willingness and ability to implement the treatment recommendations provided, no guarantees of successful treatment can be offered. In addition, responses to each aspect of treatment can be potentially unique and idiosyncratic. Though the intent of care is improvement, your responses can vary. If you have a problem that requires immediate attention, call 911, or have someone take you to the hospital emergency room. If you notice an adverse reaction to one of the components of your health plan, you should call our office and inform us of what you are observing. Medications prescribed by other physicians with whom you are working are not to be discontinued except through consultation with the doctor who prescribed each medication. You further acknowledge that, unless you initiate a specific doctor-patient process with her, Dr. Cheryl Yanuck is not in any way involved in your case.

Your doctor may determine that the procedures listed below may be beneficial in the diagnosis or treatment of your condition. Upon your signed consent below, such operations or special procedures may be performed for you by your doctor and/or by other technical staff selected by him. This authorization applies both to the listed procedures and to advice given as part of your care. In your doctor's absence, this consent applies to the doctor or staff selected to provide coverage for emergencies.

Your signature below constitutes your acknowledgment that: (I) you have read and agreed to the foregoing: (2) You understand that each procedure will be discussed with you before it is done, and that if this discussion is not sufficient to provide your understanding, it is your responsibility to request more information (3) You authorize and consent to the performance of procedure(s) or specific tests (4) You consent to the performance of procedures and tests in addition to or different from those specified below whether or not arising from presently unforeseen conditions which your doctor or his associates or assistants may consider necessary or advisable in the course of the procedure(s) specified below: (5) No guarantee of a cure has been promised to you. In addition to other procedures discussed at the time they are performed, procedures may include the following: manipulation, traction, exercise, heat, cold, phlebotomy, nutrition, orthopedic testing, neurologic testing, physical examination, deep muscle therapy, rehabilitation exercises, dietary instructions.

Questions:____Questions (if any) Answered & Witness by: _____________

Patient Name (Print): ____

Patient Signature:____Date_____________________

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INFORMED CONSENT FOR EXERCISE, TRAINING, AND REHABILITATIVE ACTIVITIES

The undersigned hereby voluntarily consents to engage in a program of exercise, training, and/or rehabilitative activities as the clinician deems appropriate to your case. In the course of this process, it is vital that you provide adequate feedback regarding any changes that you observe. When participating in any program involving neurological rehabilitation, it is vital that you give feedback related to any change that you observe of any sort. When engaging in an exercise program, it is important to distinguish muscular pain due to fatigue ("burning") as compared with pain experienced as a result of an injury. If an exercise causes pain, you are to stop that exercise immediately and inform the doctor or his assistant so that the exercise can be either modified or discontinued. Likewise, when a particular exercise causes pain only in a portion of the range of motion, notify the doctor or his assistant immediately and do not perform the portion of the exercise that caused pain.

As with virtually any therapeutic modality, there exists a certain risk of injury. Every effort will be made to minimize these risks through preliminary examination and by engaging in communication on the basis of your feedback.

Any questions about the procedures used in your rehabilitation or exercise program are encouraged. If you have any doubts or questions, please ask for further explanations.

It is understood that you may withdraw consent and discontinue participation in the rehabilitation or exercise program at any time by notifying the doctor.

Finally, the undersigned releases and discharges this facility, their officers, agents, staff, physicians, technicians and any others connected therewith from all claims or damages whatsoever that the undersigned or his/her representatives may have arising from, or incident to your neurologic rehabilitation or exercise program.

I have read this form and I understand the procedures that I will perform. I consent to participate in the neurological rehabilitation and/or exercise program deemed appropriate to my care by the doctor.

SIGNED____________________________________DATE______________

WITNESS___________________________________DATE______________

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THE YANUCK CENTER
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Office Policies

for

Dr. Sam Yanuck

YOUR RESPONSIBILITIES AS A PATIENT
Every effort will be made to accomplish the maximum result in the most efficient manner.
You have two primary responsibilities in support of this goal:

1. **Follow the instructions** that Dr. Yanuck gives you. These may include specific forms of exercise, changes in food, nutrition, sleep management, activity levels, or other instructions.
2. **Keep the schedule** of your visits to the office as close as possible to the recommended time of your follow up. The timing of your return is based on the specifics of your case. Waiting longer than recommended often means that you will lose ground in the process of moving your system toward normal function.

APPOINTMENTS
Dr. Yanuck spends significant time in preparation for each of your appointments. Missing an appointment is a significant disruption to the flow of that preparation process.

If an appointment must be rescheduled, no charge will be made if notice is given at least two business days in advance.
This means you need to call before 5pm **Thursday** to change a **Monday** appointment, or before noon Friday to change a **Tuesday** appointment. **If this is not done, the full amount of the visit fee will be charged.**

Dr. Yanuck does his best to run on time. However, because he works with each patient until he has accomplished what needs to be done in that session, Dr. Yanuck often runs behind schedule. Please make provisions for delays in the starting and ending times of your appointment. Do not schedule other appointments close to the ending time of your appointment with Dr. Yanuck. If you want to arrive after the scheduled start time of your appointment, please call ahead and verify how far behind he is running. **Otherwise, your appointment time starts at the scheduled time.**

FEES AND BILLING
The fee per hour is $307. **Payment is due at the end of each session. You are solely responsible for the charges you incur in the office.** You will be given forms to submit to your insurance company.

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FEES AND BILLING, continued…

The initial consultation typically takes about 90 minutes. Subsequent sessions usually last an hour. If sessions go longer or shorter, the fee is adjusted accordingly. Brief sessions are from 5 to 15 minutes. **Phone consultations are billed at the hourly rate.** There is no charge for brief questions sent by email, provided this function is kept to a minimum.

Dr. Yanuck bills as a chiropractor, so insurance policies that cover chiropractic may be expected to reimburse you to some extent for his services, though **there is no guarantee they will do so**. It is your responsibility to determine the extent of your coverage with your insurance company. At your request, our staff will attempt to give you advice about how to handle your interaction with your insurer, within the limits of their time and knowledge. Be aware that there are often two or more billing codes that are interchangeable for each of our services (one describing the time involved and one for the procedure). If there are particular billing codes your company prefers us to use to describe our services, please advise the staff. If you have trouble with your insurer, please tell us. We will try to help you, within the limits of our time and knowledge.

EMERGENCIES

In case of emergency, call our office and relay the information to the staff. Your call will be returned as soon as possible. If your emergency occurs outside the normal office hours, go to the emergency room.

CONFIDENTIALITY

Our work together is completely confidential, as are your records. Your explicit written permission is required **in each instance** to release information about your treatment to doctors, insurance companies, family members or others.

ACKNOWLEDGEMENT

I,_______________________________________, have read these policies and agree to abide by them.
(print your name)

Signed____Date _____________