

It is well known that families who maintain strong, healthy and well-aligned spines have much improved health! We welcome you to our unique, family office.

**Our Mission: To Empower and enable all people, especially children, to pursue and achieve optimal health and wellness for a lifetime.**

Today's Date: \_\_\_/\_\_\_/\_\_\_ Full Name: \_\_\_\_\_ Prefer to be called: \_\_\_\_\_

Home #: \_\_\_\_\_ Cell #: \_\_\_\_\_ Work #: \_\_\_\_\_

Address: \_\_\_\_\_

Best Email: \_\_\_\_\_ Birth date: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_

Single  Engaged  Married  Divorced  Separated  Widowed

Spouse/Fiancé Name: \_\_\_\_\_

Name and Ages of Children (if applicable): \_\_\_\_\_

Patient's Employer/Business: \_\_\_\_\_ Occupation: \_\_\_\_\_

Whom may we thank for your referral to our office? \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Relationship: \_\_\_\_\_

**Please check reasons for pursuing chiropractic care:**

\_\_\_ I'm seeking care for a work related injury? \_\_\_Y \_\_\_N Auto Accident? \_\_\_Y \_\_\_N

\_\_\_ I'm continuing ongoing care from another chiropractor. Last Adjustment \_\_\_/\_\_\_/\_\_\_ Last Exam \_\_\_/\_\_\_/\_\_\_

\_\_\_ I'm interested in wellness and natural health care.

\_\_\_ I want to improve my immune function.

\_\_\_ I'm concerned about my health and I'm looking for answers for my symptoms.

\_\_\_ I have no idea why I'm here. Please take the time to explain to me what you do.

**Your Goals & Expectations:** List your main reasons for coming into our office.

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

**Spinal misalignments can cause decay and degeneration**, making you feel like you need to twist, stretch or pop your neck/back.

**Do you ever feel the need to crack or pop you neck or back?** \_\_\_Y \_\_\_N Where? \_\_\_\_\_

**Do you ever hear noises when you move your head or neck?** \_\_\_Y \_\_\_N

In order for us to better understand your current level of health, **please mark** any of the following stressors with an **N** for now, or **P** for having the issue in the past:

- |                              |                         |                                     |                          |
|------------------------------|-------------------------|-------------------------------------|--------------------------|
| ___ Dizziness                | ___ Headache            | ___ Poor Posture                    | ___ Arthritis            |
| ___ Inherited Spinal problem | ___ Short Leg/Orthotics | ___ Ear Infection                   | ___ Intestinal Problems  |
| ___ Frequent Colds           | ___ ADD/ADHD            | ___ Sinus Problems                  | ___ High Blood Pressure  |
| ___ Bladder Problems         | ___ Kidney Problems     | ___ PMS/Cramps                      | ___ Menopausal Symptoms  |
| ___ Spinal arthritis         | ___ Spinal Curvature    | ___ Allergies                       | ___ Lung Disease         |
| ___ Fainting                 | ___ Flat Feet           | ___ Fertility Issues                | ___ Hyper/Hypothyroidism |
| ___ Diabetes                 | ___ Epilepsy            | ___ Heart Disease                   | ___ Stroke               |
| ___ Ulcers                   | ___ Multiple Sclerosis  | ___ Cancer (Type? _____ Year _____) |                          |
| ___ Fibromyalgia             | ___ Other - _____       | ___ Other - _____                   |                          |

**Prescription & Over-the-counter Medications** may cause various **side effects**, **hiding the severity of health problems and hinder the body's ability to heal.** What medications are you currently taking & for what health problem? \_\_\_\_\_

**Do you currently take vitamins or supplements?** If yes, please list: \_\_\_\_\_

**You need to drink ½ your body weight in ounces of water per day for normal body function.**

How many ounces of water do you drink a day? \_\_\_\_\_

**Stress can cause or accelerate spine damage.** Rate your **Stress** in the last 90 days.

(Circle appropriate level) : **Low 1 2 3 4 5 6 7 8 9 10 High**

How committed are you to actively participating in regaining greater levels of Health & Wellness?

Not at all 1 2 3 4 5 6 7 8 9 10 Committed 100%

**The Stress Test:** Please circle **when** you experienced the following life stresses.

(C = Childhood T = Teenager A = Adulthood)

Physical / Emotional / Chemical Stresses:

- |   |  |
|---|--|
| © T A Birth Traumas                                     | T A Career Stress                      |
| © T A Falls/Slips                                       | C T A Children Stress                  |
| C T A Car Accidents: <i>when?</i> _____                 | C T A Relationship Stress              |
| C T A Sports Injuries                                   | C T A Concealed Feeling                |
| C T A Poor Posture                                      | C T A Quick Tempered                   |
| T A Work Injuries                                       | C T A Poor Diet / Excessive Sugar      |
| T A Sitting on a Wallet                                 | C T A Artificial Sweetener: Type _____ |
| C T A Sleeping on Stomach                               | C T A Caffeine Amount: _____           |
| C T A Extensive Computer Work                           | C T A Soda Amount: _____               |
| C T A Carry Heavy Purse/Backpack/Child/ Equipment       | C T A Prescription Drugs               |
| C T A Repetitive Lifting/ Bending                       | C T A Over the counter Drugs           |
| T A Driving for many hours                              | (ex. Tylenol, Motrin, Aspirin)         |
| C T A Continuous hours sitting/standing                 | C T A Smoker/Secondhand Smoke          |
| C T A 1 + hours of Computer, TV, tablet or gaming a day | Amount: ___ pk/day ___ pk/week         |
| C T A Texting   | C T A No/Minimal Exercise              |
| C T A Other _____                                       |  |

**If you circled Yes to Car Accidents above, please complete** for each separate car accident/fender bender:

Approx Date \_\_\_/\_\_\_/\_\_\_ Hit vehicle at Front\_\_ Side\_\_ Rear-ended\_\_ . Approx Speed \_\_\_ mph. Wearing Seatbelt Y N  
Visit to ER Y N. Visit to any medical provider Y N. Injuries (list): \_\_\_\_\_

Approx Date \_\_\_/\_\_\_/\_\_\_ Hit vehicle at Front\_\_ Side\_\_ Rear-ended\_\_ . Approx Speed \_\_\_ mph. Wearing Seatbelt Y N  
Visit to ER Y N. Visit to any medical provider Y N. Injuries (list): \_\_\_\_\_

Approx Date \_\_\_/\_\_\_/\_\_\_ Hit vehicle at Front\_\_ Side\_\_ Rear-ended\_\_ . Approx Speed \_\_\_ mph. Wearing Seatbelt Y N  
Visit to ER Y N. Visit to any medical provider Y N. Injuries (list): \_\_\_\_\_

What did you do to stay active as a child? (ex. sports, activities) \_\_\_\_\_

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What do you do to stay active now? (ex. walk, tennis, workout) \_\_\_\_\_

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What are your primary stresses? 1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_

What else is very important for us to know to take great care of you? \_\_\_\_\_

Do you avoid any food groups? Y N Please list the foods and reasons why avoided. \_\_\_\_\_

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Are you interested in learning more about Toxin-Free Living options to reduce the toxic load on your body?  
(circle) Yes Maybe No I don't know what this means, please tell me more.

Have you broken a bone? No Yes: (list where and date) \_\_\_\_\_

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Have you ever had stitches? No Yes: (list where and date) \_\_\_\_\_

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List your top three major falls from childhood to now.

1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_

**What we do:** It is important that our patients and we have the same health objectives concerning chiropractic care. Regardless of what a disease or condition is called we do not offer to treat it. Our only practice objective is to eliminate a major interference to the expression of the body's internal wisdom. Our method is specific adjusting to correct vertebral subluxations (misalignments). We believe that the greatest doctor is the one already inside of each of our patients and we only help to maximize that inherent healing power, without using drugs or surgery. Your signature verifies that the information given in this form is complete and correct and that you accept, if eligible, chiropractic care on this basis.

Initial here \_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_

Is there any reason why you would not be able to follow Dr. Curran recommendations? N Y \_\_\_\_\_

**Authorization for care:** I hereby authorize the doctor to provide any and all forms of evaluation and care that may be indicated in connection with the patient above, and further authorize and consent that the doctor chooses and employs such assistance as she deems necessary. I also understand that prior to care; full explanation of the care involved will be given. My signature indicates consent for treatment. I realize that I am responsible for all fees charged by this office and I agree to pay all services provided in full and a timely manner.

Signature: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

**Authorization for care of a minor:** I hereby authorize this office and its doctor(s) to administer care as they so deem necessary to my son/daughter/ward (upon approval of parent/guardian). (Please sign if applicable.)

Signature: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_ Relationship to patient: \_\_\_\_\_

**Cornerstone Chiropractic LLC Privacy Authorization**

Our goal is to make your experience with us exceptional. Due to new laws passed to protect your privacy we request in writing your authorization to proceed with certain office practices. Your signature below will verify that (1) you have read the following procedures and do not object and (2) you have been given the option to review and understand our privacy practices. These are some of our practices and does not entail everything.

- We may welcome new patients and thank referrals with their names on a dry erase board at the front desk or by mail or email.
- We use postcards or email to wish you happy birthday, welcome you or remind you of an appointment
- We may mail health articles, newsletters and other information directly to your home or email
- We may leave a message at your home with someone or via voicemail
- We may post pictures of our “Chiropractic Kids” in the kid’s area and “Chiropractic Families” on the Family boards
- Should you share a testimonial with us, we may display it, use it in our community outreach programs or media to help others.
- Chiropractic adjustments are received in a family oriented open adjusting area.

Signature \_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_

I authorize Cornerstone Chiropractic LLC to send any radiology images to an outside radiologist for evaluation and reading. I agree to pay Cornerstone Chiropractic LLC for any fees associated with these radiology services.

Signature \_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_

I authorize all my healthcare information to be shared with the following individuals.

1. \_\_\_\_\_ Relationship to you \_\_\_\_\_
2. \_\_\_\_\_ Relationship to you \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

**Emergency Contact**

1. Name \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_
2. Name \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_

As of July 1, 2023, there will be a \$60 No Show Fee charged to you if there is no prior notice given for an appointment cancellation so others who are waiting to see the Doctor may utilize that appointment time. See the front desk for details. 24 hour notice is kindly requested.

Initial here \_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_