"Our Mission is to help as many people as possible, especially children."
It is well known that families who maintain strong, healthy and well-aligned spines have much improved health!

Today's Date: ___/___/___ Full Name:_____ Prefer to be called: _____
Birth date: ___/___/___ Age:_____
Names of Parents / Guardians: _____
Home Phone #:_____ Cell Phone #:_____ Work Phone#:_____
Address: _____
City: _____State:_____Zip Code: _____
Best Email for Parent / Guardian: _____
Whom may we thank for referring you to our office?_____
Emergency Contact Name: _____Phone: _____
Relationship to Patient: _____

Please check reasons for pursuing chiropractic care:
___ My child is continuing ongoing care from another chiropractor.
___ I'm interested in wellness and natural health care for my child.
___ I want to improve my child's immune function.
___ I'm concerned about my child's health and I'm looking for answers for their symptoms.
___ I have no idea why I'm here. Please take the time to explain to me what you do.

Your Goals & Expectations: List main reasons for your child's visit.
1. _____ 3. _____
2. _____ 4. _____

Spinal misalignments can cause decay and degeneration, making someone feel like they want to twist, stretch or pop the neck/back.
Does your child ever feel the need to crack or pop you neck or back? __Y __N
If yes, Where? _____
Does your child ever hear noises when you move your head or neck? __Y __N

Check any of the following conditions your child has suffered from:
___Ear Infections ___Scoliosis ___Seizures ___Chronic Colds ___Headaches
___Asthma/Allergies ___ADD/ADHD ___Recurring fevers ___Colic ___Growing/Back Pain
___Sinus Problems ___Car Accident ___Digestive Issue ___Bed wetting ___Learning Challenges
___ Inherited Spine Problem
___Other_____ ___Other_____
Other Health Problems that concern you?_____
Family History:_____

Poor posture leads to poor health and often indicates a spinal problem. How would you rate your child's posture?
Poor – 1 2 3 4 5 6 7 8 9 10 - Excellent

Research shows that spinal problems often begin at birth. How old was your child when they received their first Chiropractic checkup? _____ ___ Never
Previous Chiropractor:_____ Last adjustment___/___/___ Last exam___/___/___
Reason:_____ or Wellness Check ☐

Prescription medications may cause various **side effects**, **hiding the severity of the health problem(s) and hinder the body's ability to heal**. Please answer the following:
Number of Doses of Antibiotics Your Child has taken during the past six months:_____ Total during his / her lifetime:_____
Number of Doses of Other Prescription Medications Your Child has Taken during the past six months:_____ Total During his / her lifetime:_____List:_____

Please list any **current** prescription/medications and for what health problem:

_____

_____

Does your child currently take vitamins or supplements? If yes, please list:_____

_____

It is optimal to drink ½ your body weight in ounces of water per day for normal body function.
How many ounces of water does your child 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%

Prenatal History:
Long, difficult or doctor-assisted births may cause spinal misalignments.
Complications during pregnancy? ___Y ___N List:_____
Medications during pregnancy / delivery? ___Y ___N List:_____
Cigarette / Alcohol use during pregnancy? ___Y ___N
Birth Intervention: ___Forceps ___Vacuum Extraction ___Cesarean Section : emergency **or** planned Complications during delivery? ___Y ___N List:_____
How long was labor & delivery? _____

Childhood Diseases:

Chicken Pox ___Y ___N Age_____
Mumps ___Y ___N Age_____
Rubella ___Y ___N Age_____
Whooping Cough ___Y ___N Age_____
Rubeola ___Y ___N Age_____
Other_____ ___Y ___N Age_____

Trauma:
According to the National Safety Council, approximately 50% of children fall head first from a high place during their 1st year of life (i.e. a bed, changing table, stairs, etc.)
Was this the case with your child? ___No ___Yes

Has your child been involved in any high impact or contact type sports (i.e. soccer, football, gymnastics, baseball, cheerleading, martial arts, etc.) ___Y ___N
List sports & how many years:_____
What does your child do to stay active?_____

Has your child ever been involved in a car accident? ___Y ___N List:_____
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):_____

Has your child been seen on an emergency basis? ___Y ___N List:_____
Other traumas not described above?___Y ___N List:_____
Prior surgery: ___Y ___N List:_____
Menarche: ___Y ___N Age:_____
What are your child's primary stresses? 1._____2._____3._____

What else is very important for us to know to take great care of your child?

_____

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

_____

_____

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

Has your child broken a bone? No Yes: (list where and date)

_____

Has your child ever had stitches? No Yes: (list where and date)

_____

Has your child had surgery? No Yes: (list where and date)

_____

List your top three major falls from birth to present.
1._____ 2._____ 3._____

The Stress Test: Please circle ***WHEN*** you experienced the following stresses: (**C** = Childhood **T** = Teenager)

Physical / Emotional / Chemical Stresses:

© **T** Birth Traumas
© **T** Falls/Slips
C T Car Accidents: Date(s)_____ _____
C T Sports Injuries
C T Poor Posture
T Work Injuries
T Sitting on a Wallet
C T Sleeping on Stomach
C T Extensive Computer Work
C T Carry Heavy Purse/Backpack/Child/ Equipment
C T Repetitive Lifting/ Bending
T Driving for many hours
C T Continuous hours sitting/standing
C T 1 + hours of Screen or Gaming
C T Texting
C T Other_____

T Career Stress
C T Children Stress
C T Relationship Stress
C T Concealed Feeling
C T Quick Tempered
C T Poor Diet / Excessive Sugar
C T Artificial Sweetener: Type _____
C T Caffeine Amount:_____
C T Soda Amount: _____
C T Prescription Drugs
C T Over the counter Drugs
(ex. Tylenol, Motrin, Aspirin)
C T Smoker/Second Hand Smoke
Amount: ___ pk/day ___ pk/week
C T No/Minimal Exercise

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 for your child? No Yes

N Y _____

Authorization for care of minor: 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 deemed necessary to my son/daughter/ward (upon approval of parent/guardian). I also understand that prior to care, full explanation of the care involved will be given. My signature indicates consent for treatment and that I have the irrevocable ability to give such permission in total. I realize that I am responsible for all fees charged by this office and I agree to pay all services provided.

Signature:_____ Date:____/____/____ Relationship to patient:_____

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:____/____/____ Relationship to patient:_____

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

1._____ Relationship to you_____
2._____ Relationship to you_____

Signature:_____ Date:____/____/____ Relationship to patient:_____

Cornerstone Chiropractic 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 on an 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:____/____/____ Relationship to patient:_____

As of January 1, 2011 there will be a $55 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 ___/___/___