

“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. _____
2. _____
3. _____
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?

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 \$50 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 ____/____/____