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?_____

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. _____ 3. _____
2. _____ 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** Falls/Slips
C T A Car Accidents: *when*?_____
C T A Sports Injuries
C T A Poor Posture
T A Work Injuries
T A Sitting on a Wallet
C T A Sleeping on Stomach
C T A Extensive Computer Work
C T A Carry Heavy Purse/Backpack/Child/ Equipment
C T A Repetitive Lifting/ Bending
T A Driving for many hours
C T A Continuous hours sitting/standing
C T A 1 + hours of Computer, TV, tablet or gaming a day
C T A Texting
C T A Other_____

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

If you circled Yes to Car Accidents above, <u>please complete</u> 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)_____

_____

What do you do to stay active now? (ex. walk, tennis, workout_____
_____

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. _____
_____
_____

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) _____
_____

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

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:____/____/____

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 ___/___/___