"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!

We welcome you to our unique, family office.

Today's Date: __/__/__ Full Name:_____ Prefer to be called: _____
Male/Female Birth date: ____/____/____ Age:_____
Names of Parents / Guardians: _____
Home Phone #:_____ Cell Phone #:_____ Work Phone#:_____
Address: _____
City: _____State:_____ZipCode: _____
EMAIL: _____
How did you hear Dr. Curran and the office?_____

Please check reasons for pursuing chiropractic care:

____ My child is continuing ongoing care from another chiropractor. Last exam__/__/__ Last x-ray__/__/__
____ 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.

Check any of the following conditions your child has suffered from during the past six months:

____Ear Infections ____Scoliosis ____Seizures ____Chronic Colds ____Headaches
____Asthma/Allergies ____ADHD ____Recurring fevers ____Colic ____Growing/Back Pain
____Bed wetting ____Car Accident ____Digestive Problems ____Temper Tantrums
Other Health Problems?_____
Family History:_____

Research shows that spinal problems often begin at birth.

How old was your child when they received their first Chiropractic checkup? _____ ____ Never
Previous Chiropractor:_____ Date of last visit:_____
Reason:_____ or Wellness Check ☐
Name of Pediatrician:_____ Date of last visit:_____
Reason:_____
Are you satisfied with the care which your child has received there? ____Y ____N

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_____
Vaccination History:_____

Prenatal History:

Name of Midwife/Obstetrician:_____
Complications during pregnancy? ____Y ____N List:_____
Ultrasounds during pregnancy? ____Y ____N Number:_____
Medications during pregnancy / delivery? ____Y ____N List:_____
Cigarette / Alcohol use during pregnancy? ____Y ____N
Location of Birth: _____Hospital _____Birthing Center _____Home _____Other:_____
Birth: ____Vaginal ____Forceps ____Vacuum Extraction ____Ceasarian Section : emergency **or** planned
Complications during delivery? ____Y ____N List:_____
Presence at birth of: Jaundice (yellow) ____Y ____N :: Cyanosis (blue)____Y ____N
Genetic Disorders or Disabilities: ____Y ____N List:_____
Birth Weight:_____ Birth Length:_____ APGAR Scores:_____, _____
Was delivery within 2 weeks of due date?____Y ____N # of days premature / late:_____
Number of hours of sleep each night?_____ Quality of Sleep? Good_____ Fair_____ Poor_____

Feeding History:

Breast fed: ___Y ___N How long?_____
Formula fed: ___Y ___N How long?_____ Type:_____
Introduced to solids at: _____months; Cow's Milk at _____months
Food / Juice Allergies or Intolerances: ___Y ___N List:_____

Developmental History:
During the following times your child is most vulnerable to stress and should routinely be checked by a doctor of chiropractic for prevention and early detection of vertebral subluxation (spinal nerve interference).
At what age was your child able to:
_____Respond to Sound _____Cross Crawl _____Respond to Visual Stimuli _____Stand Alone
_____Hold Head Up _____Walk Alone _____Sit Up

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 ever been involved in a car accident? ___Y ___N 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:_____

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_____

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 ___/___/___

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 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. 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:_____

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.

- 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.

Initial here _____ 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 ___/___/___

Current Health Form

Name: _____ Birthdate: ____/____/____ Date: ____/____/____

What is your Primary Reasons for today's visit?

☐ Wellness/Maintenance Visit (If yes, no need to complete.) ☐ I have a body issue. (Complete **all** questions below.)

PLEASE CHOOSE ONE :

Check one, and complete below info concerning the selected issue only

☐ **Headaches** ☐ **Allergies** ☐ **Sinus'** ☐ **Cold/Flu** ☐ **Stress** ☐ **Other** _____

☐ **Neck** ☐ **Mid Back** ☐ **Lower back** ☐ **Pelvis** ☐ **Hip** ☐ **Extremity:** _____

Is it on the: ☐ Left Side ☐ Right Side ☐ Centered ☐ Other _____
Does it travel? ☐ No ☐ Yes If yes, where? _____
Is this a: ☐ New ☐ Flare-Up ☐ Chronic condition?
When did it start? ____/____/____
What caused it? _____ ☐ Unknown
How many times does it bother you? (Please circle day or week) ☐Constant ☐0-25% per **day / wk**

☐ 26-50% per **day / wk** ☐ 51-75% per **day / wk** ☐ 76-100% per **day / wk**

Describe the discomfort: ☐ Ache ☐ Sharp ☐ Burning ☐ Tingling ☐ Numb ☐ Tight ☐ Pulling
☐ Other _____
Discomfort Scale: **No Pain** = 0 1 2 3 4 5 6 7 8 9 10 = **Unbearable Pain**
What makes it worse? 1. _____ 2. _____
What makes it better? 1. _____ 2. _____
How has it changed your daily activities? 1. _____ 2. _____
Other treatments/Doctors seen for this? 1. _____ 2. _____

PLEASE CHOOSE ONE : of the following issues

Check one, and complete below info concerning the selected issue only

☐ **Headaches** ☐ **Allergies** ☐ **Sinus'** ☐ **Cold/Flu** ☐ **Stress** ☐ **Other** _____

☐ **Neck** ☐ **Mid Back** ☐ **Lower back** ☐ **Pelvis** ☐ **Hip** ☐ **Extremity:** _____

Is it on the: ☐ Left Side ☐ Right Side ☐ Centered ☐ Other _____
Does it travel? ☐ No ☐ Yes If yes, where? _____
Is this a: ☐ New ☐ Flare-Up ☐ Chronic condition?
When did it start? ____/____/____
What caused it? _____ ☐ Unknown
How many times does it bother you? (Please circle day or week) ☐Constant ☐0-25% per **day / wk**

☐ 26-50% per **day / wk** ☐ 51-75% per **day / wk** ☐ 76-100% per **day / wk**

Describe the discomfort: ☐ Ache ☐ Sharp ☐ Burning ☐ Tingling ☐ Numb ☐ Tight ☐ Pulling
☐ Other _____
Discomfort Scale: **No Pain** = 0 1 2 3 4 5 6 7 8 9 10 = **Unbearable Pain**
What makes it worse? 1. _____ 2. _____
What makes it better? 1. _____ 2. _____
How has it changed your daily activities? 1. _____
2. _____
Other treatments/Doctors seen for this? 1. _____
2. _____

(Complete another form if needed.)

Mark an **X** on areas bothering you on the diagram

Mark an → if it travels