CORNERSTONE FAMILY CHIROPRACTIC, INC.

PH: (774) 847-7474 | 15 NORTH MAIN STREET, STE B-5

INFO@CORNERSTONEFAMCHIRO.COM | BELLINGHAM, MA 02019

"What should I expect in today's exam?"

Our Objective:

The objective of our practice is to improve the health and well-being of the spine and nervous system to help you get back to your life. We accomplish this by locating, analyzing and correcting vertebral subluxation complexes (spinal misalignments with aberrant motion affecting proper functioning of the nervous system). The vertebral subluxation complex creates damage to the vertebrae resulting in disc, joint, muscle and nerve injury.

Subluxations impact your daily life experience; reducing your emotional, physical and intellectual well-being. The longer these subluxations remain uncorrected, the more damage occurs and the longer it takes to correct. Even newborns can experience spinal damage from the birth process.

Our vision is to assist individuals and families in regaining and maintaining their health throughout their life.

Today's Visit

After completing all necessary paperwork, the doctor will conduct a thorough health history, consultation, and examination to see if you or your child are/is a candidate for Chiropractic care. In addition, the doctor may conduct several specialized exams depending on the case. If the doctor feels that you/your child may benefit from care, an x-ray study may be recommended to aid in assessment of spinal health and with the prognosis for care.

Following the completion of your examination, you will be asked to schedule a follow up appointment where the doctor will review findings of the evaluation with you. It is our intention to exceed your expectations and provide you with the ***highest quality of service*** and Chiropractic care.

Insurance

We are an ***out-of-network provider*** for all insurance networks. If your insurance plan has "out-of-network" benefits, we will be happy to provide you with any appropriate paperwork to aid with full reimbursement up to your policy limits. This model allows us to offer ***high quality care*** for your family at an ***affordable*** price.

*We feel strongly that patient care and your family's health should be based on clinical need and not on **insurance limitations**.*

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HEALTH HISTORY FORM (CHILD)

15 NORTH MAIN ST. STE B-5
BELLINGHAM, MA 02019

Please fill out this form as completely and accurately as possible.

Today's Date__________________

PERSONAL DATA

Name____Age__________Date of Birth_______________________

Parents' Names (*if you are under 18*)____

Home Address__________________________________City_______________________State________Zip___________

Home Phone (____)________________________________Work Phone (____)___________________________________

Cell Phone (____)____________________________ Cell Phone Provider _____________________ (For text reminders)

Email Address____

Marital Status ☐ S ☐M ☐D ☐W Spouse's/Partner's Name:____

How did you hear of the office? ☐ Patient________________________________ ☐ Google ☐ Facebook

☐ Practitioner / Doctor__________________________________ ☐ Other___________________

REASON FOR SEEKING CHIROPRACTIC CARE

What concerns do you feel Cornerstone Family Chiropractic, Inc. can address for your child?

☐ Wellness & Spinal Vertebral Subluxation Evaluation

☐Other:____

Are these concerns affecting your child's quality of life? (*Please circle "Y" or "N".*)

Sleep:	Y	N	Sitting:	Y	N	Other:	Y	N
School:	Y	N	Walking:	Y	N			
Exercise/Sports:	Y	N	Eating:	Y	N			

HEALTH CARE PRACTITIONER HISTORY

Has your child ever received Chiropractic care? ☐ Yes ☐ No Name of D.C.___________________________________

Under care for how long? ☐_______days ☐_______weeks ☐_______months ☐______years

Date of last visit:_____________________ Why did treatment stop?____

___________________________ How was your child's experience?_______________________________________

Have you consulted or do you regularly consult with any of the following providers for your child? (*Check all that apply.*)

☐ Medical Physician ☐ Naturopath ☐ Acupuncturist ☐ Homeopath

☐ Massage Therapist ☐ Psychotherapist ☐ Energy Healer ☐ Dentist

Reason why:____

HEALTH, VITALITY AND CHIROPRACTIC CARE

The primary system in the body, which coordinates health by balancing all cellular functions, is the ***nervous system including the brain****.*

The vertebrae, the bones of the spinal column, surround and protect this delicate ***nervous system,*** *and their joints contain several* ***neurological receptors*** *which* ***stimulate many areas of the brain*** *through neurological connections.*

Chiropractors are specialists trained in "early detection" of injury to the ***spine and nervous system.***
The information below will help us to see the types of ***PHYSICAL, EMOTIONAL AND CHEMICAL*** *stressors to which your child has been subjected to and* ***how they may relate to your child's present spinal, nerve and health status.***

MOTHER'S PREGNANCY AND LABOR

The birth process can traumatize a newborn's spine and cause damage to the spinal column and nerve system.

Please indicate where your child was birthed:
☐ Home ☐ Hospital ☐ Birthing Center ☐ Other________________________________

During pregnancy, did the mother:

...take any medication? ☐ Yes ☐ No Explain:____

…smoke or consume alcohol? ☐ Yes ☐ No

…experience any illness? ☐ Yes ☐ No Explain:____

During labor, was the baby's position different from head down? ☐Yes ☐No

Approximately, how long did labor last? _____________hours

Was labor chemically induced? ☐Yes ☐No

Was labor doctor assisted? ☐Yes ☐No

Was a C-Section performed? ☐Yes ☐No

Was forceps / vacuum extraction used? ☐Yes ☐No

During delivery, did the doctor pull or twist baby? ☐Yes ☐No

Was the delivery premature? ☐Yes ☐No

If "Yes," at ____________months and ______________ weight

Check any of the following if the child experienced immediately after birth:

☐Jaundice ☐Respiratory Problems ☐Feeding Problems ☐Displaced / Broken Joints ☐Other

Explain:____

PHYSICAL

Has your child ever fallen down, tripped or hit his/her head? ☐Yes ☐No
Has your child ever fallen when learning to sit-up, stand, walk, run, etc? ☐Yes ☐No
Has your child ever broken a bone, sprained or dislocated a joint? ☐Yes ☐No
Has your child ever been involved in a motor vehicle accident? ☐Yes ☐No
Is your child actively involved in any sport activities? ☐Yes ☐No
Has your child ever undergone any surgeries? ☐Yes ☐No
Has your child ever been hospitalized? ☐Yes ☐No

EMOTIONAL

It is too difficult to separate the emotional stress in our life from the physical response that often occurs.
Please indicate if your child has in the past experienced or continues to experience any of the emotional stressors below:

☐Childhood Trauma ☐Loss of Loved One ☐Lifestyle Change ☐School
☐Financial ☐Abuse ☐Chronic Illness ☐Parents' Divorce

NUTRITIONAL / CHEMICAL

Chemical stress can occur when a there is a deficiency of a required nutrient for our cells' proper functions, or when a toxic substance is inhaled, injected, taken orally or placed on the skin (e.g. drug reactions, exposure to chemicals in the air, eating processed foods, etc). The following will reveal exposures your child may have had.

Was your child vaccinated? ☐Y ☐N
If yes, did he/she exhibit any changes (physical, behavioral)? ☐Y ☐N

Has your child been exposed to any of the following on a regular basis – past or present?
☐Antibiotics ☐Second-Hand Smoke ☐Drug Therapy
☐Radiation ☐Toxic Chemicals ☐Other________________________

Please list all medications, and for which ***specific conditions or symptoms they were prescribed***:

____

(NOTE: IT IS IMPERATIVE THAT YOU LIST ALL MEDICATIONS AS THEY MAY HAVE AN INFLUENCE ON YOUR CHILD'S CARE.)

Does your child regularly take any vitamins or supplements? ☐Yes ☐No

If so, please specify:____

Was/Is your child breastfed? ☐Y ☐N

If "Yes", for how long?___________________________ What percentage of diet was/is breast milk?_______%

If the child is/was breast fed, does/did the mother's diet contain any of the following?:
☐Caffeine ☐Alcohol ☐Chocolate ☐Medications ☐Supplements

If the child is/was breast fed, how is/was the mother's diet?:____

____

If solids were already introduced to child's diet, which ones?____
Was the child fed: ☐Home-made foods ☐Store bought

Did your child's diet include any of the following before 1 year of age?
☐Cow's Milk ☐Soy ☐Sugar ☐Trans-fat
☐Wheat/Grains ☐White Flour ☐Nuts ☐Corn

GENERAL HISTORY

Has your child suffered from any of the following health problems?:

☐Hyperactivity	☐Ear Infections	☐Difficulty Sleeping
☐Bed Wetting	☐Irritability	☐Colic
☐Frequent Colds	☐Diarrhea	☐Constipation
☐Gas Pains	☐Rashes/Eczema	☐Milk/Lactose Intolerance
☐Food Sensitivities	☐Allergies	☐Asthma
☐Headaches	☐Learning Disorders	☐Poor Posture
☐Chicken Pox	☐Pneumonia	☐Whooping Cough
☐Measles	☐Flu	☐Diabetes
☐Cancer	☐Conjunctivitis ("Pink Eye")	☐Tubes in Ears
☐Frequent Colds	☐Other____	

How much does the child sleep per day on average?____

How long does the child sleep overnight?_________________________ Any daytime naps?_________________

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CONSENT TO TREAT A MINOR
(CHILD UNDER 18)

"I hereby request and authorize Dr. Timothy J. Murzycki of Cornerstone Family Chiropractic, Inc. to perform diagnostic tests and render chiropractic adjustments and other treatments as Dr. Murzycki deems appropriate to my child,_______________________________________ (hereinafter "Patient").
(PRINT NAME OF MINOR)

This authorization also extends to any and all other doctors and trained office staff employed by Cornerstone Family Chiropractic, Inc. and is intended to include radiographic examination at the discretion of the doctor. As of this date, I represent that I have the legal right to select and authorize health care services for the Patient.

(If applicable) Under the terms and conditions of my divorce, separation or legal authorization, the consent of my spouse/former spouse or other parent is not required. If my authority to so select and authorize this care should be revoked or modified in any way, I shall immediately notify Cornerstone Family Chiropractic, Inc."

OFFICE POLICIES

"I clearly understand and agree that all services rendered for treatment are charged directly to me and that I am personally responsible for the payment of the same in a timely manner. I will not hold any doctor, employed by Cornerstone Family Chiropractic, Inc., responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand that if my care is suspended or terminated, any fees for professional services rendered to date will become immediately due and payable. In the event I fail to timely pay any fees for professional services rendered, I understand that I will be responsible for any additional costs and expenses, including but not limited to collection and/or legal costs incurred in order to secure payment.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and policy holder. I understand that Cornerstone Family Chiropractic, Inc. will prepare any necessary reports and forms to assist me in collecting from the insurance company.

I acknowledge that some patients may experience mild discomfort due to examination procedures. I hereby authorize the Doctor to examine and diagnose my child's condition, as he or she deems appropriate."

(By signing below, I hereby consent to care provided by Cornerstone Family Chiropractic, Inc. for the minor listed herein and acknowledge and agree to abide by the office policies as provided above.)

SIGNATURE: ___________________________________ ***DATE***:_________________________

PRINTED NAME: ___________________________________ ***RELATIONSHIP TO PATIENT***:________________

Notice of Privacy Practices

We are concerned with protecting your privacy especially in matters that concern your personal health information. In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), we are required to supply you with a copy of our privacy policy and procedures. We encourage you to read this document for it outlines the use and limitations of the disclosure of your health information and your rights as a patient. If you have any questions or concerns regarding the use or dissemination of your personal information, we would be happy to address them.

"I have received a copy of the HIPAA for Cornerstone Family Chiropractic, Inc."

____ _____ /_____ /_____

Signature Date

Terms of Acceptance

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working toward the same objective.

Chiropractic has only one goal. It is important that each patient understands both the objective and the method that will be used to attain it.

Adjustment – An adjustment is the specific application of forces that facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Subluxation – A misalignment of one or more of the 24 vertebra in the spinal column, which causes alteration of nerve function and interference to the transmission of mental impulses resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it, nor do we offer advice regarding treatment prescribed by others. *Our only practice objective is to eliminate a major interference to the expression of the body's innate wisdom.* Our only method is specific **adjustments** to correct vertebral subluxations.

"I understand that I have the right to have all of my questions pertaining to the purpose of chiropractic care answered to my complete satisfaction prior to my first adjustment. "

____ ______ /______ /______

Signature **Date**