



CORNERSTONE FAMILY CHIROPRACTIC, INC.

PH: (774) 847-7474

INFO@CORNERSTONEFAMCHIRO.COM

15 NORTH MAIN STREET, STE B-5

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 a ***Direct Pay Office***. 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**.*



CORNERSTONE FAMILY CHIROPRACTIC, INC. HEALTH HISTORY FORM (ADULT)

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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 (____) _____ Email Address _____

Occupation _____ Employer _____

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

Names and Ages of Children _____

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 you?

Wellness & Spinal Vertebral Subluxation Evaluation

Other: _____

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

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

HEALTH CARE PRACTITIONER HISTORY

Have you ever received Chiropractic care? Y N Name of D.C. _____

Under care for how long? _____ days _____ weeks _____ months _____ years

Date of last visit: _____ Why did you stop? _____

How was your experience? _____

Permission for Xrays:

If an X-Ray study is recommended, your signature is required (below) for your consent. **Women, by signing below you verify that you are not pregnant.** (If any question that you are pregnant, please notify the doctor.)

Signature: _____ Date: _____

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 areas of stress and indicators of how your body may be functioning for either health and adaptation, or stress and compensation.

CHIROPRACTIC CLINICAL OBJECTIVE

Physical, emotional and nutritional/chemical stressors, common to our contemporary lifestyles and environments, can result in dysfunctional areas in the spinal column and interferences to neurological communication. This is called **Vertebral Subluxation Complexes**. The Chiropractic evaluation is specifically designed to detect Vertebral Subluxation Complexes in all phases of their progression.

Many common symptoms and conditions are caused by the interference on the nerve system and by imbalances of the body due to our environmental stressors. Please place an (X) on conditions that you are currently suffering from and an (O) on any conditions you have had in the past.

- | | | |
|---|---|---|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Headache | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Back Curvature | <input type="checkbox"/> Migraine Headache | <input type="checkbox"/> Chest Pain |
| <input type="checkbox"/> Mental / Emotional Disorders | <input type="checkbox"/> Neck Pain (R / L) | <input type="checkbox"/> Difficulty Breathing |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Shoulder Pain (R / L) | <input type="checkbox"/> Heart Problems |
| <input type="checkbox"/> Swollen or Painful Joints | <input type="checkbox"/> Numbness/Tingling
in arms, or hands (R / L) | <input type="checkbox"/> Heart Attack |
| <input type="checkbox"/> Convulsions / Epilepsy | <input type="checkbox"/> Carpal Tunnel Syndrome | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Skin Problems | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Bruit |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Ringing in Ears | <input type="checkbox"/> High / Low Blood Pressure |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Varicose Veins |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Liver Trouble |
| <input type="checkbox"/> Frequent Colds | <input type="checkbox"/> Digestive Problems | <input type="checkbox"/> Gall Bladder Trouble |
| <input type="checkbox"/> Upper Back Pain / Stiffness | <input type="checkbox"/> Depression | <input type="checkbox"/> Mid-Back Pain / Stiffness |
| <input type="checkbox"/> Excessive Gas | <input type="checkbox"/> Attention Disorder | <input type="checkbox"/> Pain with cough/Bowel Mvmt |
| <input type="checkbox"/> Constipation / Diarrhea | <input type="checkbox"/> Anxiety Disorder | <input type="checkbox"/> Hip Pain |
| <input type="checkbox"/> Prostate Problems | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Low Back Pain/Stiffness |
| <input type="checkbox"/> Impotence | <input type="checkbox"/> Trouble Concentrating | <input type="checkbox"/> Sciatica |
| <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Loss of Memory | <input type="checkbox"/> Numbness/Tingling in
legs or feet (R / L) |
| <input type="checkbox"/> Frequent Urination | <input type="checkbox"/> Ear Infection | <input type="checkbox"/> Muscle Tightness |
| <input type="checkbox"/> Menstrual Problems / PMS | <input type="checkbox"/> Learning Disability | <input type="checkbox"/> Trouble Sleeping |
| <input type="checkbox"/> Menopausal Problems | | |



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., being a Direct Pay Office, will willingly prepare any necessary reports and forms to assist me in collecting from the insurance company up to my policy limits.

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

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

DATE: _____

SIGNATURE: _____

PRINTED NAME: _____

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



***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."

SIGNATURE: _____

DATE: _____

PRINTED NAME: _____

RELATIONSHIP TO PATIENT: _____