



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**.*



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:

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Childhood Trauma | <input type="checkbox"/> Loss of Loved One | <input type="checkbox"/> Lifestyle Change | <input type="checkbox"/> School |
| <input type="checkbox"/> Financial | <input type="checkbox"/> Abuse | <input type="checkbox"/> Chronic Illness | <input type="checkbox"/> Parents' Divorce |

NUTRITIONAL / CHEMICAL

Chemical stress can occur when 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?

- | | | |
|--------------------------------------|--|---------------------------------------|
| <input type="checkbox"/> Antibiotics | <input type="checkbox"/> Second-Hand Smoke | <input type="checkbox"/> Drug Therapy |
| <input type="checkbox"/> Radiation | <input type="checkbox"/> Toxic Chemicals | <input type="checkbox"/> 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?:

- | | | | | |
|-----------------------------------|----------------------------------|------------------------------------|--------------------------------------|--------------------------------------|
| <input type="checkbox"/> Caffeine | <input type="checkbox"/> Alcohol | <input type="checkbox"/> Chocolate | <input type="checkbox"/> Medications | <input type="checkbox"/> 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?

- | | | | |
|---------------------------------------|--------------------------------------|--------------------------------|------------------------------------|
| <input type="checkbox"/> Cow's Milk | <input type="checkbox"/> Soy | <input type="checkbox"/> Sugar | <input type="checkbox"/> Trans-fat |
| <input type="checkbox"/> Wheat/Grains | <input type="checkbox"/> White Flour | <input type="checkbox"/> Nuts | <input type="checkbox"/> Corn |

GENERAL HISTORY

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

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

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

How long does the child sleep overnight? _____

Any daytime naps? _____



***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., being a Direct Pay Office, 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