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**.*

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.**

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HEALTH HISTORY FORM (CHILD)

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

Purpose of this visit: ○ Wellness Check-up ○ Injury or Accident ○ Other

Please explain:

_____

If your child is experiencing **pain/discomfort, please identify where and for how long:**

_____

_____

1. When did the problem first begin? Date: _____-_____-_____ ○ Unknown ○ Gradual ○ Sudden
2. Has this problem occurred before? ○ No ○ Yes If yes, when?
   _____
3. Have you seen any other doctors for this problem? ○ No ○ Yes **If yes**, whom?
   _____
4. How long ago? _____ Days _____ Weeks _____ Months _____ Years
5. What were the results of past treatment?
   _____
6. How is this problem NOW?
   ○ Rapidly Improving ○ Improving Slowly ○ About the Same ○ Gradually Worsening ○ On and Off
7. Please list any medication(s) taken for this problem:
   _____
8. 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		

Reviewing Doctor's Initials: _____ Date Reviewed: _____

Patient's Name: _____ DOB: _____ Date: _____

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? _____

PREGNANCY, LABOR, INFANCY HISTORY

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

Did the mother experience any complications during your pregnancy? (check all that apply)

☐ Back/Other Pain ☐ Swelling ☐Pre/Eclampsia ☐ Strep B

☐ Nausea/Vomiting ☐ Pre-Term ☐Fatigue ☐ Gestational Diabetes

☐Other (please describe): _____

Type of birth (check all that apply):

☐ Hospital ☐ Birth Center ☐ Home ☐ Normal /Vaginal

☐ Breech Cesarean ☐ Scheduled/Induced ☐ Epidural

☐ Forceps/Vacuum Extraction

Problems during labor / delivery? _____

☐ Antibiotics ☐ Congenital Anomalies ☐ Failure to Thrive ☐ Jaundice

☐ Meconium Respiratory Distress ☐ Extended Hospitalization ☐ Feeding Problems

☐ Other: _____

Infant Feeding:

☐ Breast ☐ Bottle ☐ Formula

Have you vaccinated your child?

☐ No ☐ Yes ☐ As Scheduled ☐ Delayed Schedule

Reviewing Doctor's Initials: _____ Date Reviewed: _____

Patient's Name: _____ DOB: _____ Date: _____

ALLERGIES, MEDICATIONS, SURGERIES & FAMILY HISTORY

Allergies (List):

_____
_____
_____

Medications (List):

_____
_____
_____

Surgeries (List):

_____
_____
_____

Family History (List):

_____
_____
_____

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

GENERAL HISTORY

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

☐Hyperactivity	☐Ear Infections	☐Diarrhea	☐Conjunctivitis ("Pink Eye")
☐Bed Wetting	☐Irritability	☐Rashes/Eczema	☐Difficulty Sleeping
☐Frequent Colds	☐Allergies	☐Learning Disorders	☐Colic
☐Gas Pains	☐Pneumonia	☐Flu	☐Constipation
☐Food Sensitivities	☐Asthma	☐Poor Posture	☐Milk/Lactose Intolerance
☐Headaches	☐Whooping Cough	☐Diabetes	☐Tubes in Ears
☐Chicken Pox	☐Anemia	☐Dizziness	☐Fainting
☐Measles	☐Sinus Trouble	☐Orthopedic problems	☐Joint Problems
☐Cancer	☐Digestive Disorders	☐Poor Appetite	☐Reflux
☐Frequent Colds	☐ Walking Problems	☐Behavioral Problems	☐ADD/ADHD
☐Ruptures/Hernia	☐Muscle Pains	☐Growing Pains	☐Delayed Speech

☐ Other: _____

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

How long does the child sleep overnight? _____ Any daytime naps?_____

Reviewing Doctor's Initials: _____ Date Reviewed: _____

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. **INITIAL: _____**

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. **INITIAL: _____**

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."
INITIAL: _____

(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**