



Patient Information	
Date:	
SSN (required for insurance)	
Childs Name	
Last	
First Middle	
Address	
City	
StateZip	
Email	
Sex: Male Female Age	
Birthdate:	
Family Information	
Father's Name	
Father's work phone	
Father's work phone	
Mother's Name	
Mother's Cell phone	
Mother's work phone	
Child's Home phone	
Parent's Marital Status: Please Circle Answer	
Married Widowed Separated Divorced Livi	
Reason for Seeking Chiropractic (Please briefly describe the main concern that	
like us to address for your child	you would
into as to addites for your office	
Our goals at Cornerstone Family Chiropractic address your concerns that brought you to ou second, to offer your child the opportunity of in	r office and

health, wellness and quality of life for present and future.

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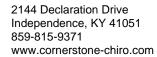
Who is responsible for this account?		
Relationship to Patient		
Insurance Company		
Group #		
Subscriber ID		
Insured's name		
Insured's birthdate		
Insured's SSN		
Insured's relationship to patient		
Is patient covered by additional insurance	YES	NO
Insurance Company		
Insured's Info		

ASSIGNMENT AND RELEASE

I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

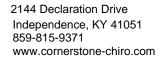
The patient (guardian) understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a detailed account of our policies and procedures concerning the privacy of you Patient Health Information we encourage you to read the HIPPA NOTICE that is available to you at the front desk before signing this consent. The Following person(s) have my permission to receive my personal health Information:

Guardians Signature:______Date___





		Wicalc	al Doctor Illioriii	ation	
Who is	the Child's pediatrician?				
Name o	of their Office				
Office A	Address				
Office T	elephone Number				
Date of	their last visit	Rea	son		
Are you	ı satisfied with the care yo	ur child receives at t	his office? YES	NO	
When d	loctors work together it bei	nefits you. May we h	nave your permission	on to update your	medical doctor regarding your
care at	this office? YES	NO			
Other d			ealth Care Histor	-	Chirorpactor Other
	•				
1.	Name		ity	L	Date
	X-rays taken? YES N	O Spe	ecial Test done?	NO YES	
	Diagnosis		Treat	ments Received_	
2.	Name	C	City	[Date
	X-rays taken? YES N	O Spe	ecial Test done?	NO YES	
	Diagnosis		Treat	ments Received_	
	ur child ever had Chiroprad	ctic care? NO			
If Yes,	name of DC Date of last visit				
	Date of last visit		vviiy was c	are stopped?	
	Were you satisfied with the	e care your child re	ceived? YES	NO	
Has you	ur child, or does he/she re	gularly consult with	any of the following	providers? (circl	e all that apply)
M	Medical Doctor	Naturopath	Acupuncturis	:	Homeopath
M	lassage Therapist	Optometrist	Dentist		Psychotherapist





The CENTRAL NERVOUS SYSTEM is the system within the body which coordinated health.

This system is surrounded and protected by the bones of the SPINAL COLUMN (vertebrae).

Chiropractors are specialists trained in "early detection" of injury to the SPINE and NERVOUS SYSTEM

The Information that you provide us below will help us see the possible types of PHYSICAL, CHEMICAL, and EMOTIONAL stresses your child has been subjected to and how they may relate to his/her current spinal, nerve and health status.

Child's Health Profile

GENERAL HISTORY

Ple	ase circ	الد عاا	symptoms	vou child has	ever had	even if they	/ do not	seem releva	ant to the	current	condition
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	Ear infection	Seizures		Chronic colds	Asthma
	Allergies	Digestive proble	ems	ADHD	Recurrent Fever
	Colic	Anemia		Reflux	Behavioral Problems
	Leg Problems	Diabetes		Heart Trouble	Orthopedic Problem
	Neck Problems	Joint Problems		Constipation	Diarrhea
	Poor Appetite	Arm Problems		Back Problems	Trouble Walking
	Sinus Problems	Excessive Gas		Other:	
Please	e list any serious medical	condition(s) you o	child cui	rrently has or has had:_	
PREN	ATAL HISTORY				
Name	of Obstetrician/Midwife_				
Social	History while pregnant: (Circle all that appl	ly)		
	Did you: Exerc	ise Regularly		Eat a balanced diet	Obtain sufficient rest
	Did you smoke?	YES	NO	If yes, Packs/day	
	Did you drink alcohol?	YES	NO	If yes, drinks/day	
	Did you drink caffeine?	YES	NO	If yes, in what form ((coffee, tea, etc.)



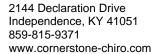
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Medications/Supplements taken while pregnant- Please L	List:
Where their complications during pregnancy? NO	YES If Yes, please explain
LABOR AND DELIVERY	
Location of birth:	
Birth interventions: (please circle) Forceps Vacuum	n extraction Epidural Cesarean Section (emergency or planned)
Were there complications during delivery? NO	YES If yes, please explain:
Birth weight (pounds) Birth length	n (inches) APGAR scores
FEEDING HISTORY	
Breast fed: NO YES If yes, how long?	
Formula fed: NO YES If yes, how long?	Formula brand:
Does the baby prefer feeding on one side more that the o	other? NO YES If yes, which side?
After feeding does the baby frequently spit up? NO	YES
Introduced solids atmonths	Introduced to cow's milk atmonths
Food/Drink allergies, sensitivities or intolerances:	NO YES If yes, please list:



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PHYSICAL STRESS Has your child ever suffered fr	om the following	spinal tr	aumas'	? (please circl	e is yes)	
Fall in baby walker	Fall from bed	or couch		Fall off swi	ng	Fall from highchair
Fall from crib	Fall down stai	rs		Fall off slid	Э	Fall of changing table
Other:		_				
Has your child ever been in a	car accident?	YES	NO	If yes, plea	se explain:	
Has your child ever had a bon	e fracture or a joi	nt disloca	ation?	YES NO	•	, please explain:
Has your child had any other t	raumas not desc	ribed abo	ove?	YES NO		, please explain:
Does your child sleep through	the night?	YES	NO			
On average how man	y hours of sleep of	does you	r child s	leep at night?		
CHEMICAL STRESS						
Vaccination history: (please ci	rcle) Up to	date	Chose	e to decline va	accination	Other:
	Still d	eciding o	n which	vaccinations	and at wha	t age to allow administration
Please describe any adverse	reactions to any v	/accinatio	ons:			
Number of doses of antibiotics	s your child has ta	aken: Dur	ing the	first 6 months		total during lifetime
EMOTIONAL STRESS						
Does your child have difficulty	concentrating?	YES	NO			
Does your child get angry eas	ily? YES	NO				





Developmental Accomplishments

Please check all skills your child can perform in each section

		С,
GROSS MOTOR SKI	11:	. 7

- □ Holds head up from table momentarily
- Pushes up with hands and forearms
- □ Can be pulled into a sitting position by hands
- □ Sits unsupported in the upright position
- □ Rolls from back to belly
- □ Crawls
- □ Stand holding onto something
- □ Walks with someone holding onto one hand
- Walks unassisted
- □ Negotiates stairs placing 2 feet on each step
- □ Negotiates stairs placing 1 foot on each step
- □ Hops on 1 foot

SOCIAL SKILLS

- □ Smiles
- □ Reaches for familiar objects
- □ Plays with hands
- □ Plays with feet
- □ Clearly shows joy and pleasure
- □ Feeds self with fingers
- □ Plays peek-a-boo
- □ Understands yes and no

COMMUNICATION SKILLS

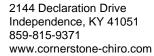
- □ Makes cooing sounds
- □ Laughs
- □ Uses 1 syllable words such as "ma"
- □ Uses 2 syllable words such as "mama"

FINE MOTOR SKILLS

- ☐ Grabs your finger when put in palm
- □ Holds and shakes a rattle placed in the hand
- □ Grabs objects by him/her self
- Moves an object from one hand to the other
- □ Self feeding- can hold and eat a cracker
- □ Checks objects by placing them in the mouth
- Picks up object with thumb and pointer finger
- □ Turns 2 to 3 pages of a book at same time
- □ Turns 2 page of a book at a time
- ☐ Builds a tower containing at least 5 blocks
- □ Builds a tower containing at least 10 block

ADAPTIVE SKILLS

- Drinks from a cup unassisted
- □ Holds own bottle
- □ Feeds self with spook and fork
- □ Able to identify and match some colors
- Copies a circle
- □ Copies a cross





Additional Questions		
If there is a need for dietary changed or nutrients, would you like to be informed? If there is a need for a specific exercises, would you like to be informed?	YES YES	NO NO
If there is need for support in the emotional/stress area of health would you like to be informed?	YES	NO
Is there any specific health topic you would like more information on?		
Evnectations		

I would like my child to have the following benefits from chiropractic care: (check all that apply)

- □ Relief of a symptom or problem
- Relief and prevention of a symptom or problem
- □ Healthier spine and nerve system
- Best possible health on all levels

Medications	Allergies	Vitamins/Supplements

Please Read and Sign Below

The information I have provided on these forms is correct and accurate to the best of my knowledge. I give Dr. Robison
permission to administer care to my son/daughter as they deem necessary. The initial visit includes a professional and
complete health history/consultation and chiropractic examination/evaluation.

Signature of parent or guardian	date
Signature of witness	date

Thank you for choosing Cornerstone Family Chiropractic!

We Look forward to helping you obtain Better Health and Better Life