CORNERSTONE FAMILY CHIROPRACTIC

2144 Declaration Drive
Independence, KY 41051
859-815-9371
www.cornerstone-chiro.com

Patient Information

Date:_____

SSN (required for insurance)_____

Childs Name_____

Last

_____

First Middle

Address_____

City_____

State_____ Zip_____

Email_____

Sex: Male Female Age_____

Birthdate:_____

Family Information

Father's Name_____

Fathers cell 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 Living Together

Reason for Seeking Chiropractic Care

Please briefly describe the main concern that you would like us to address for your child_____

_____

_____

Our goals at Cornerstone Family Chiropractic are to first address your concerns that brought you to our office and second, to offer your child the opportunity of improved health, wellness and quality of life for present and future.

Insurance

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**_____

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Medical Doctor Information

Who is the Child's pediatrician?_____

Name of their Office_____

Office Address_____

Office Telephone Number_____

Date of their last visit_____ Reason_____

Are you satisfied with the care your child receives at this office? YES NO

When doctors work together it benefits you. May we have your permission to update your medical doctor regarding your care at this office? YES NO

Health Care History

Other doctors you have consulted for condition that brings you to our office: (circle) MD Chirorpactor Other-_____

1. Name_____ City _____ Date_____

   X-rays taken? YES NO Special Test done? NO YES_____

   Diagnosis_____ Treatments Received_____

2. Name_____ City _____ Date_____

   X-rays taken? YES NO Special Test done? NO YES_____

   Diagnosis_____ Treatments Received_____

Has your child ever had Chiropractic care? NO YES

If yes, name of DC_____ Time under care_____

Date of last visit_____ Why was care stopped?_____

Were you satisfied with the care your child received? YES NO

Has your child, or does he/she regularly consult with any of the following providers? (Circle all that apply)

Medical Doctor Naturopath Acupuncturist Homeopath

Massage Therapist Optometrist Dentist Psychotherapist

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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

Please circle all symptoms you child has ever had, even if they do not seem relevant to the current condition:

Ear infection	Seizures	Chronic colds	Asthma
Allergies	Digestive problems	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 list any serious medical condition(s) you child currently has or has had:_____

_____

_____

PRENATAL HISTORY

Name of Obstetrician/Midwife_____

Social History while pregnant: (Circle all that apply)

Did you: Exercise 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 List:_____

_____ _____

_____ _____

Where their complications during pregnancy? NO YES If Yes, please explain_____

_____

LABOR AND DELIVERY

Location of birth:_____

Birth interventions: (please circle) Forceps Vacuum extraction Epidural Cesarean Section (emergency or planned)

Were there complications during delivery? NO YES If yes, please explain:_____

_____

Birth weight (pounds)_____ Birth length (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 other? NO YES If yes, which side?_____

After feeding does the baby frequently spit up? NO YES

Introduced solids at _____months Introduced to cow's milk at _____months

Food/Drink allergies, sensitivities or intolerances: NO YES If yes, please list:_____

_____

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PHYSICAL STRESS

Has your child ever suffered from the following **spinal traumas?** (please circle is yes)

Fall in baby walker Fall from bed or couch Fall off swing Fall from highchair

Fall from crib Fall down stairs Fall off slide Fall of changing table

Fall from Monkey Bars Other:_____ _____

Has your child ever been involved in organized sports (i.e. football, soccer, baseball, basketball, gymnastics, cheerleading, martial arts, etc.)? NO YES If yes, which ones_____

Has your child ever been in a car accident? YES NO If yes, please explain:_____

_____

Has your child ever had a bone fracture or a joint dislocation? YES NO If yes, please explain:_____

_____

Has your child had any other traumas not described above? YES NO If yes, please explain:_____

_____

Do you feel your child's book bag is too heavy for him/her? NO YES

How many hours per day does your child do each of the following?

Watch TV_____ Use a computer_____ Play video games_____

Does your child sleep through the night? YES NO

On average how many hours of sleep does your child sleep at night?_____

CHEMICAL STRESS

History: (please circle) Up to date Chose to decline vaccination Other: _____

Still deciding on which vaccinations and at what age to allow administration

Please describe any adverse reactions to any vaccinations:_____

Number of doses of antibiotics your child has taken: During the first 6 months_____ total during lifetime_____

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EMOTIONAL STRESS

Does your child have difficulty concentrating? YES NO If yes, please explain_____

_____

Does your child complain of feeling overwhelmed or frustrated? YES NO If yes, please explain_____

_____

Does your child get angry easily? YES NO If yes, please explain_____

_____

Additional Questions

If there is a need for dietary changed or nutrients, would you like to be informed? YES NO
If there is a need for a specific exercises, would you like to be informed? YES NO

If there is need for support in the emotional/stress area of health would you like to be informed? YES NO

Do you have concerns about your child's diet? YES NO

Is there any specific health topic you would like more information on?_____

Is the current complaint affecting your child's quality of life? (please circle all the things affected)

School Exercise/sports Eating Sleep Hobby:_____ Other:_____

Expectations

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

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Please list any and all medications that you child may be taking and the reason for each. This includes over the counter medications given on an occasional basis

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