New Pediatric Application

This form is for pediatrics only. Please ask the front desk for our pregnancy or adult forms.

Today's Date: ____/____/____ **Age:** _____ **Male / Female** **Date of Birth**_____/_____/_____

Name: _____ **Parent or Guardians Name:** _____

Address: _____ **City:** _____ **State:** _____**Zip:** _____

Primary Phone: _____ **Email:** _____

For confirming appointments and important updates do you prefer? TEXT or EMAIL

Who may we thank for referring you? _____

Is your child currently receiving care from any other health professionals? YES / NO

If yes, who, and what is their specialty? _____

Has your child ever been adjusted before? YES / NO

If yes, how was your experience?

GOOD / BAD / INDIFFERENT

What would you like to gain from chiropractic care?

☐ Symptom Relief ☐ Overall Wellness ☐ Both

What are your health goals for your child?

1. _____
2. _____
3. _____

Please list the reasons for bringing your child to our office:

1_____

2_____

3_____

Please list all medications, prescriptions, vitamins & supplements they are currently taking:
(If you have a list please provide along with this paperwork)

_____

Pregnancy, Labor, & Delivery

Did the mother smoke during pregnancy? ☐ YES ☐ NO If yes, how often? _____

Did the mother drink alcohol during pregnancy? ☐ YES ☐ NO If yes, how often? _____

Did the mother use recreational drugs during pregnancy? ☐ YES ☐ NO If yes, explain: _____

Child's birth was: ☐ Natural Vaginal Birth ☐ Scheduled C-Section ☐ Emergency C-Section

At how many weeks was your child born? _____ **Child's Birth Weight:** _____ **Child's Birth Height:** _____

Child's birth was: ☐ At home ☐ At a birthing center ☐ At a hospital ☐ Other: _____

Growth & Development

Is/was your child breastfed? ☐ YES ☐ NO If yes, how long? _____

Is/Was there difficulty breastfeeding? ☐ YES ☐ NO

Did/does your child ever experience colic, reflux, or constipation? ☐ YES ☐ NO If yes, please circle which one/s.

Did/Does your child frequently arch their neck/back, feel stiff, or bang their head? ☐ YES ☐ NO If yes, please explain: _____

☐ N/A **Please list any food intolerances or allergies and when they began:** _____

☐ N/A **Please list any hospitalizations and or surgical history:** _____

☐ N/A **Has your child ever experienced being knocked unconscious, fainting, or seizures:** ☐ YES ☐ NO

If yes please explain: _____

☐ N/A **Please list any major injuries, accidents, falls and/or fractures your child has sustained in his/her lifetime:** _____

Does your child have difficulty sleeping? ☐ YES ☐ NO If yes, please explain: _____

Does your child experience night terrors? ☐ YES ☐ NO

Does your child express behavioral, social, or emotional issues? ☐ YES ☐ NO If yes, please explain: _____

_____

How many hours per day does your child typically spend watching tv, computer, tablet, or phone? _____

Is there anything additional you would like to add that you feel our doctor needs to know about?

_____

_____

_____

Notice of Privacy Practices Acknowledgment

I understand that I have certain rights of privacy regarding my protected health information, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

1. Conduct, plan, and direct my care and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations, such as quality assessments and Physician's certifications.

I acknowledge that I may request your NOTICE OF PRIVACY PRACTICES containing a more complete description of the uses and disclosures of my health information. I also understand that I may request, in writing, that you restrict how my private information is used to disclose to carry out care, payment, or healthcare operation. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

I request and authorize Cornerstone Family Chiropractic to release my health information to the following parties:

Name: _____ **Relationship to me: _____**

Name: _____ **Relationship to me: _____**

Signature _____ **Date: _____/_____/_____**
(Required)

Terms of Acceptance

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both the Doctor and the patient to be working towards the same objective.

Our main goal is to help your body (specifically your spine and nervous system) become more mobile, adaptable, and functional. When this is achieved often times you will feel better as a result. It is important that each practice member understand both the objective and the method that will be used to ascertain it. This will prevent any confusion or disappointment.

ADJUSTMENT: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxations. Our chiropractic method of correction is by specific adjustments to the spine or extremities.

HEALTH: A state of optimal physical, mental, and social well-being, not merely the absence of symptoms or disease.

VERTEBRAL 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.

Our main goals and objectives are to locate and correct vertebral subluxations of the spine. Chiropractic is not designed to make you instantly feel better, rather the chiropractic method is and has always been to improve your body's ability to adapt and cope with both the internal and external stresses. We have laid out clear objective and subjective measures for care. During active care we will actively measure subjective and objective improvement through various ways of measurement. Once discharged from active care you will be given the opportunity to continue with supportive or maintenance care (both supportive and maintenance care are not covered by insurance). At any time during your care with us, if we find unusual finding or are unable to reach any of the subjective or objective goals set, we will provide a referral to a care provider better suited to care for that specific need. We do not offer any other services besides chiropractic care in our office. It is your responsibility to be consistent with the at home instructions that our doctors provide.

FIRST DAY COSTS: You will be responsible to pay in full for all first day costs including co-pays prior to leaving; including but not limited to: evaluations, x-rays, first day adjustments. Unless our office staff has in writing any other arrangement for payment. First day adjustment pricing does differ from adjustment pricing that will be built into your care plan. We will disclose any and all pricing prior to rendering services.

I, _____ have read & fully understand the above statements.
Print Name

Signature _____ **Date: _____/_____/_____**
(Required)

Informed Consent for Chiropractic Care

Chiropractic care, like all forms of health care while offering considerable benefits may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases, injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include, but not limited to: sprain/strain injuries, irritation of a disc condition, fractures. One of the rarest complications associated with chiropractic care occurring at a rate of one instance per one per two million cervical spine (neck) adjustments may be a vertebral injury that could lead to a stroke.

Prior to receiving chiropractic care in this office, a health history and physical examination will be completed. These procedures are performed to assess your child's specific conditions, your child's overall health, and in particular your child's spinal health. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies are needed. In addition, they will help us determine if there is any reason to modify your child's care or provide you with a referral to another health care provider. All relevant findings will be provided to you along with a care plan prior to beginning care.

I understand and accept that there are risks associated with chiropractic care and I give full consent to the examination that the doctor deems necessary and the chiropractic care including: spinal adjustments, therapies, and evaluations as reported following my initial assessment.

If you do not wish to have ANY part of your child's spine checked and adjusted, please do not sign and notify either one of the chiropractic assistants or the doctor to discuss your concern prior to receiving care. Please note, an adjustment for a newborn or infant, as well as young children are much different than that of an adjustment on an adult. The doctor will do a face-to-face interview with you with full explanation of procedures as well as answer questions you may have prior to having your child adjusted.

Print _____

Signature _____ **Date:** _____/_____/_____
(Required)

_____
Witness Signature (Office Staff)

X-Ray Authorization
For Children 12 and older

As your healthcare provider, we are legally responsible for your chiropractic records. We must maintain a record of your x-rays in our files. At your request, we will provide you with a copy of the x-rays in our files. Additional requests for copies may have an associated fee.
Please note: x-rays are utilized primarily in this office to help locate and analyze the presence of vertebral subluxations. These x-rays are not used to investigate for medical pathology. If any abnormalities are found, we will bring it to your attention so that you can seek proper medical advice.

BY SIGNING BELOW, YOU ARE AGREEING TO THE ABOVE TERMS & CONDITIONS

Parent of Guardian Printed Name: _____

Parent of Guardian Signature _____ **Date:** _____/_____/_____