928.237.9477
www.CFC4FamilyHealth.com
2225 E State Route 69 Suite A
Prescott, AZ 86301

New Practice Member Pediatric Form

Child's Name: ________________________________ Child's Date of Birth_____/_____/_____

Today's Date: ____/____/____ Age: _________ Male / Female

Mother's Name: _____________________________ Mother's DOB: _____________

Father's Name: _____________________________ Father's DOB: ______________

Parent or Guardian Address: ____

City: __________________ State: _____ Zip: ________

Parent or Guardian Phone: Home_____________________ Cell________________________

Cell Provider________________ (this will allow us to send you reminders for future appointments)

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

Parent or Guardian Email: ____

Purpose of this visit: ___ Wellness ___ Injury or Accident ___ Other

Who may we thank for referring you? ____

Current Health Information

List your child's primary health concerns or health goals below:

Health Concerns/Goals: (List according to severity)	Rate of Severity 1= Mild 10=Unbearable	When did the Symptoms Start?	Are the Symptoms Constant or Intermittent?
1______________________	______________	______________	______________
2______________________	______________	______________	______________
3______________________	______________	______________	______________
4______________________	______________	______________	______________
5______________________	______________	______________	______________

Please circle if you are currently experiencing:

ADD/ADHD	Chronic Sinusitis	Headaches	Sciatica L / R	Anxiety
Depression	Heart Disorder	Low Back Pain	Shoulder Pain L / R	Epilepsy
Asthma	Dizziness	Hip Pain L / R	Stomach Disorder	Allergies
Ear Infection/s	Irritable Bowel	Mid-Back Pain	Bladder Complications	Nausea
Migraines	TMJ Disorder	Chest Pain	Kidney Stones	Ulcers
Chronic Fatigue	Gastric Reflux	Knee Pain L/R	Neck Pain	Vertigo
Numbness in *Face*	Numbness in *Arms*	Numbness in *Hands*	Numbness in *Legs*	Numbness in *Feet*

Any other health condition not listed above: _________ ___________ _______________________

____________________ ____________________ ____________________ __________________

Please list all medications or prescriptions your child is currently taking:
(If you have a list please provide along with this paperwork)

____

____

____

CORNERSTONE FAMILY CHIROPRACTIC

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.

Chiropractic has only one goal. 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.

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.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxations. However, if during the course of chiropractic spinal examination, we encounter non-chiropractic or unusual finding, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of another health care provider. Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. Cornerstone Family Chiropractic's objective is to eliminate interference within the Central Nervous Systems. Our only method is specific adjusting to correct vertebral subluxations.

I, ________________________________ have read & fully understand the above statements.

Print Name

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

CORNERSTONE
FAMILY CHIROPRACTIC

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

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 Physicians 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.

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

X-Ray Authorization

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.

PLEASE NOTE: X-RAYS ARE UTILIZED IN THIS OFFICE TO HELP LOCATE AND ANALYZE VERTEBRAL SUBLUXATIONS. THESE X-RAYS ARE NOT USED TO INVESTIGATE FOR MEDICAL PATHOLOGY. THE DOCTORS OF CORNERSTONE FAMILY CHIROPRACTIC DO NOT DIAGNOSE OR TREAT MEDICAL CONDITIONS; HOWEVER, 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

Print ______________________________________

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

FEMALE PATIENTS ONLY:
TO THE BEST OF MY KNOWLEDGE, I BELIEVE I AM NOT
PREGNANT AT THE TIME X-RAYS ARE TAKEN AT CORNERSTONE FAMILY CHIROPRACTIC.

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

CORNERSTONE
FAMILY CHIROPRACTIC

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: SPRAIN/ STRAIN INJURIES, IRRITATION OF A DISC CONDITION, AND RARELY FRACTURES. ONE OF THE RAREST COMPLICATIONS ASSOCIATED WITH CHIROPRACTIC CARE OCCURRING AT A RATE BETWEEN ONE INSTANCE PER ONE MILLION TO 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 CHIROPRACTIC OFFICE, A HEALTH HISTORY AND PHYSICAL EXAMINATION WILL BE COMPLETED. THESE PROCEDURES ARE PERFORMED TO ASSESS YOUR SPECIFIC CONDITIONS, YOUR OVERALL HEALTH AND IN PARTICULAR YOUR 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 CARE OR PROVIDE YOU WITH A REFERRAL TO ANOTHER HEALTH CARE PROVIDER. ALL RELEVANT FINDINGS WILL BE REPORTED 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 CONSENT TO THE EXAMINATION THAT THE DOCTOR DEEMS NECESSARY AND THE CHIROPRACTIC CARE, INCLUDING SPINAL ADJUSTMENTS, AS REPORTED FOLLOWING MY ASSESSMENT.

CORNERSTONE FAMILY CHIROPRACTIC

Print ____

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

____
Witness Signature (Office Staff)