CORNERstone
CHIROPRACTIC & WELLNESS

153 S Main St Shawano, WI 54166

WELCOME TO FAMILY WELLNESS – WE'RE GLAD YOU ARE HERE

Child's Name: _____ Age: _____ Today's Date: _____

Mailing Address: _____City: _____

St: ____ Zip:_____

Child's Birth date: ____/____/____ Gender: Male / Female Weight: _____# SSN #: _____

Phone (Child): _____ Preferred Contact: Parent / Child / Either **Parent/Guardian Info:**

Your Name: _____ Age: _____ Birth date: _____/_____/_____

Your Address (☐ SAME): _____

SSN#:_____ No. of Children: _____ Phone: _____

E-Mail: _____ I Am: ☐ Married ☐ Single ☐ Divorced ☐ Partnered ☐ Widowed

Occupation/Employer/School: _____

Emergency Contact/Relationship: _____Phone: _____

How did you hear about us? ☐ Location ☐ Doctor ☐ Internet ☐ Ins Co Referral ☐ Friend or Family Member

Who can we thank for referring you? _____

We promise to treat you and your family with respect, compassion, and understanding.

ADDRESSING THE ISSUES THAT BROUGHT YOU TO THE OFFICE

Reason for today's visit? _____

If your child has no symptoms or complaints, and are here for wellness services, please check (√) here ☐. Skip to **"Your Health History"** Or, describe the **chief area of complaint**, including the effect it has on your child:

_____

_____

Is the purpose of this visit related to: ☐ Sports ☐ Auto ☐ Fall ☐ Home Injury ☐ Other _____

When did this condition begin? _____

Since the problem started, it is: ☐ About the same ☐ Comes & goes ☐ Getting better ☐ Getting worse

What makes it worse: _____

Does it interfere with: ☐ Sleeping ☐ Walking ☐ Daily Routines ☐ Eating ☐ Elimination

Has your Child seen other Doctors for this problem (please list):

☐ Chiropractor _____

☐ Medical Doctor _____

☐ Other / Alternative Care _____

List any medications your child is currently taking: _____

Describe your current home stress (0 = none / 10 = extreme): _____ Rate each Area for Your Child:

Diet: ☐ Poor ☐ Good ☐ Excellent Sleep: ☐ Poor ☐ Good ☐ Excellent

Exercise: ☐ Poor ☐ Good ☐ Excellent General Health: ☐ Poor ☐ Good ☐ Excellent

Have you chosen to vaccinate your child? ☐ Yes ☐ No If yes, check all that your child has received:

☐ DPaT ☐ MMR ☐ Chicken Pox ☐ Hepatitis ☐ HPV/Gardasil ☐ Flu/Influenza ☐ PCV ☐ IPV ☐ Unsure

YOUR CHILD'S HEALTH HISTORY

Please check (√) all symptoms your child has had, even if they do not seem related to your current problem.

- □ Headaches
- □ Hyperactivity ADD / ADHD
- □ Attention Problems
- □ Skin problems
- □ Constipation
- □ Digestive Problems
- □ Other: _____
- □ Bed Wetting
- □ Allergies
- □ Irritability
- □ Colic
- □ Ear Infections
- □ Vision Problems
- □ Frequent Colds
- □ Asthma
- □ Breathing Problems
- □ Sleeping Problems
- □ Tubes in Ears
- □ Moodiness / Mood swings

MOTHER'S PREGNANCY & LABOR CHILD'S CURRENT HEALTH STATUS

why this section is important: As a Wellness Center, we focus on your ability to be healthy. Our goals are, first, to address the issues that brought you to this office, and second, to offer you the opportunity of improved health potential and wellness services in the future. On a daily basis we experience physical, chemical and emotional stresses that can accumulate and result in serious loss of health potential. Most times the effects are gradual: not even felt until they become serious. Answering the following questions will give us a profile of the specific stresses you and your child have faced, allowing us to better assess the challenges to your health potential.

Please answer the following questions the best you can:

Did your child experience any physical injures? (falls, car accidents, etc)	Yes	No	Unsure	Did you suffer traumas (physical or emotional) during pregnancy?	Yes	No	Unsure
Is your child "accident prone"?	Yes	No	Unsure	Was your delivery chemically induced, C-section, forceps or vacuum assisted?	Yes	No	Unsure
Did/does your child play youth sports?	Yes	No	Unsure	Did / do you nurse the baby? If Yes, for how long? _____	Yes	No	Unsure
Has your child fallen/jumped from a height over three feet? (i.e. crib, bunk bed , trees)	Yes	No	Unsure	Did / does your baby have colic?	Yes	No	Unsure
Was or is there any use of medicine such as antibiotics or an inhaler?	Yes	No	Unsure	Have you noticed any nervousness, twitches, shakes or rocking?	Yes	No	Unsure
Did you take / use any drugs during your pregnancy? (medicine/tobacco/alcohol)	Yes	No	Unsure	Did does your child have difficulty interacting with others?	Yes	No	Unsure

AWARENESS WITH CHIROPRACTIC PRINCIPLES

Were you aware that:

	YES	NO		YES	NO
Doctors of Chiropractic work with the nervous system?	□	□	Chiropractic is the largest natural healing profession in the world?	□	□
The nervous system controls all bodily functions and systems?	□	□	If Chiropractic care starts at birth, you can achieve a higher level of health throughout life?	□	□

GOALS FOR MY CHILD'S CARE

People see Chiropractors for a variety of reasons. We will weigh your needs and desires when recommending your care plan. Please check ✓ the type of care desired.

☐ Relief Care – Symptomatic relief of pain or discomfort.
☐ Corrective Care – Correcting and relieving the cause of the problems as well as the symptoms.
☐ Comprehensive Care – Bring whatever is malfunctioning in the body to the highest state of health possible.
☐ I want the Doctor to select and recommend the type of care appropriate for my child.

You're almost done, just one more page!

AUTHORIZATION FOR CARE OF MINOR CHILD

I am the parent and/or legal guardian of this child and have the ability to make medical decisions on behalf of this child. I have elected to seek care for him/her at the Cornerstone Chiropractic for the conditions described in this form and for overall enhanced wellness of this child.

I hereby authorize the doctors of Cornerstone Chiropractic & Wellness and their staff to administer chiropractic care to my minor child including chiropractic adjustments, therapies and any examination or diagnostic procedures needed to adequately treat him/her. The doctors will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I agree to be an informed partner in the treatment of my child.

I understand that the chiropractic method of correction of subluxation is by specific adjustments to the joints of the body. The clinic does not offer to diagnose or treat any disease or condition other than vertebral subluxation. If they encounter non-chiropractic or unusual findings, I will be advised so that I can seek the services of a health care provider that specializes in that area.

studies show ...
Chiropractic Kids are Healthier!

_____
Signature of Parent, Guardian or Personal Representative

PAYMENT INFORMATION

How will payment be made? □ Self / Cash □ Health Insurance □ Auto/Injury Insurance □ School Insurance
□ Medicare □ Medicaid/BadgerCare □ Other: _____

Carrier Name: _____

Primary Insured: (if not you): _____DOB: _____

Insurance SSN or Group # _____

Date of Injury (If applicable): _____Claim #_____

Auto Ins Name: _____ Attorney Name: _____

INSURANCE ASSIGNMENT & RELEASE OF RECORDS

I certify that I, and /or my dependent(s), have insurance coverage with the above Carrier and assign directly to Cornerstone Chiropractic & Wellness all insurance benefits, if any otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Cornerstone Chiropractic & Wellness may use my health care information and may disclose such information to my insurance carrier(s) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

I hereby authorize the doctors at Cornerstone Chiropractic & Wellness to perform an examination, including x-rays if indicated, and to provide chiropractic services to me (or my dependants) based on the information provided herein.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please **Print Name** of Patient, Parent, Guardian or Personal Representative

OFFICE OPTIONS:

□ YES □ NO Please Text or Email me appointment reminders when needed.
□ YES □ NO I would like to discuss payment options in order to afford care that I may need.
□ YES □ NO I am interested in long-term wellness for my family.

Welcome to our office! Want more information? Visit us online on Facebook

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