LIFE SPRING CHIROPRACTIC

1224-B Columbia Ave. Suite 210 | Franklin, TN 37064
(615) 465-8327 | www.lifespringchiropractic.org

Office use:
Patient #____________
Account Date__________

Patient Information

Patient's Name: ____
(First) (MI) (Last)

Goes by name: ______________________________

❑Male ❑Female Birth Date: ____/____/________ Age: _____
SSN: _____-____-_____

Mothers Name:_________________ Father's Name: _________________
Parent's marital status: ❑Married ❑Single ❑Divorced ❑Widowed
Address: ____
____
(City) (State) (Zip)

Email: ____
Phone Numbers: Home: (_____)___________________________
Mother's Cell: (_____)___________________________
Father's Cell: (_____)___________________________
(Please circle the best number to reach you)
Name of school: __________________________ Grade: _____________

Emergency Contact:
Name:__________________________ Relationship to you: ___________
Home phone: ____________________ Work phone: _________________

Names/Ages of other children in the family: _____________________
____

Whom may we thank for referring you? _________________________

Main reason for today's visit: ______________________________

Release For Care & Insurance:

I hereby authorize this office and its doctors to administer care to myself or my dependent(s) as they deem necessary. I clearly understand and agree that I am personally responsible for payment of all fees charged by this office. I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility and duty to inform this office of any future changes in medical status including any accidents, injuries, falls, etc.

I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I acknowledge that the filing of my insurance is done as a courtesy by the provider and does not release me of my obligation to pay for services. I also authorize the provider the release information required to process the insurance claims. I authorize the use of my signature on all insurance submissions. This is to serve as a long term authorization. It may be revoked in writing.

Signed ___________________________Date: __________
(Patient's or Authorized person's signature)

Insurance Information
Who is responsible for this account? ___________________
Relationship to patient: _________________
Subscriber's DOB:______ Subscriber's SS# _____________
Insurance Co.:_________________________________
Member ID # _________________________________
Group # ____________________________________
Is patient covered by any additional insurance? ❑Yes ❑No

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

Name of Primary Care Physician: ______________________________
Phone: _________________________________

Name of other professionals with whom you've sought care for this condition:
______________________________Phone: _______________________

Are you currently being treated for any other conditions or symptoms? ______
____

I authorize Life Spring Chiropractic to receive any necessary medical information regarding but not limited to progress notes, physical exams notes, daily chart notes, and x-ray reports from the doctors listed above.
Signed ____________________________________Date_______________
(Patient's or Authorized person's signature)

Medications:
Number of doses of antibiotics your child has taken:
In the past 6 months _____, Total during their lifetime ____

Number of doses of other prescription medications your child has taken: In the past 6 months ____, In their lifetime ____
List: ____
____

What over-the-counter medications has your child taken: ___
____

Vaccination history: ______________________________

Does your child take supplements/vitamins? Y/N
List: ____

Prenatal History
Name of Obstetrician / Midwife:________________________________
Complications During Pregnancy? N ❑ Y ❑ List:____
Was your Child Breech? N ❑ Y ❑
Ultrasounds During Pregnancy? N ❑ Y ❑ How many?______
Medications During Pregnancy/Delivery? N ❑ Y ❑ List:___________________________________
Cigarette/Alcohol Use During Pregnancy: N ❑ Y ❑
Location of Birth: Hospital / Birthing Center / Home (circle one)
Birth Intervention: Forceps / Vacuum Extraction / C-Section (Emergency or Planned?)
Complications During Delivery? N ❑ Y ❑ List:____
Genetic Disorders or Disabilities: N ❑ Y ❑ List:____
Birth Weight:________ Birth Length:_________ APGAR scores:___________

Feeding History:
Breast Fed: N ❑ Y ❑ How Long? _______ Formula Fed: N ❑ Y ❑ How Long? _______ Type:_________________
Introduced to Solids at :______Months Cows Milk:_______Months
Food/Juice Allergies or Intolerances: N ❑ Y ❑ List:____________________________________

Developmental History:
During the following times your child's spine is most vulnerable to stress and should routinely be checked by a doctor of chiropractic for prevention and early detection of vertebral subluxation (spinal nerve interference). At what age was your child able to:

_____Respond to Sound
_____Respond to Visual Stimuli
_____Hold Head Up
_____Sit Up
_____Stand Alone
_____Cross Crawl
_____Walk Alone

According to the National Safety Council, approximately 50% of children fall head first from a high place during their first year of life (i.e., a bed, changing table, down stairs, etc.) Was this the case with your child? N ❑ Y ❑

Is/has your child been involved in any high impact or contact type sports (i.e. Soccer, Football, Gymnastics, Baseball, Cheerleading, Martial Arts, etc.?) N ❑ Y ❑ List:____
Has Your Child Ever Been Involved in a Car Accident? N ❑ Y ❑ List:______________________
Has Your Child Been Seen on an Emergency Basis? N ❑ Y ❑ List:_______________________
Other Traumas Not Described Above? N ❑ Y ❑ List:___________________________________
Surgeries? N ❑ Y ❑ List:____
Begun menstrual cycles (for girls): N ❑ Y ❑ Age______

Sleeping Habits:
Any problems with bed-time?____
In what position does your child sleep?_______________________________________
Hours total that your child sleeps?_______
Do they wake in the night? N ❑ Y ❑ How many times? ______
Does this child, or any other child of yours have problems with bedwetting? N ❑ Y ❑

Childhood Diseases:
Chicken Pox N ❑ Y ❑ Age____
Rubella N ❑ Y ❑ Age____
Rubeola N ❑ Y ❑ Age____
Mumps N ❑ Y ❑ Age____
Whooping Cough N ❑ Y ❑ Age____
Other N ❑ Y ❑ Age____

Exercise

- ❑ None
- ❑ Light
- ❑ Moderate
- ❑ Heavy

Regular Activity

- ❑ Computer/Video Games
- ❑ Sitting
- ❑ Standing
- ❑ Heavy book bag/backpack
- ❑ Very Active/Sports

WE ARE HERE TO SERVE YOU AND ENCOURAGE YOU TO ASK QUESTIONS.
YOUR PARTICIPATION IS VITAL AND WILL HELP DETERMINE YOUR RESULTS.

Please indicate if your child has had any of the following conditions:

- ❑ Headaches
- ❑ Neck Pain/Stiff Neck
- ❑ Asthma/Allergies
- ❑ Ear Infections
- ❑ Back Pain
- ❑ Nervousness
- ❑ Tension
- ❑ Irritability
- ❑ Colic
- ❑ Dizziness
- ❑ Shoulder/Neck/Arm Pain
- ❑ Numbness in Fingers/Toes
- ❑ Scoliosis
- ❑ Breathing Problems
- ❑ Fatigue
- ❑ Broken Bones
- ❑ Fractures
- ❑ ADD/ADHD
- ❑ Temper Tantrums
- ❑ Lights Bother Eyes
- ❑ Ears Ringing
- ❑ Eating Disorder
- ❑ Loss of Balance
- ❑ Fainting
- ❑ Loss of Smell
- ❑ Loss of Taste
- ❑ Unusual Bowel
- ❑ Addictions
- ❑ Weakness in Arms/Legs
- ❑ Muscle Spasms
- ❑ Frequent Colds
- ❑ Recurring Fever
- ❑ Sinus Problems
- ❑ Diabetes
- ❑ Indigestion
- ❑ Weight Loss/Gain
- ❑ Depression
- ❑ Loss of Memory
- ❑ HIV Positive
- ❑ Seizures/Epilepsy
- ❑ Digestive Problems
- ❑ Heart Disease
- ❑ Cancer
- ❑ Other:______________
- ❑ Other:______________

Family History

Please indicate known health conditions of family members:

Condition	Child: Name__________ Age [ ]	Child: Name__________ Age [ ]	Child: Name__________ Age [ ]	Spouse Name__________ Age [ ]	Father	Mother	Siblings
Arthritis							
Asthma							
Back Trouble							
Bursitis							
Cancer							
Constipation							
Diabetes							
Disc Problem							
Migraine							
Pinched Nerve							
Headaches							
Heart Trouble							
High Blood Pressure							
Insomnia							
Scoliosis							
Sinus Trouble							
Stomach Trouble							

Patient Acknowledgement and Receipt of Notice of Privacy Practices
Pursuant to HIPAA and Consent for Use of Health Information

The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant To HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request.

The undersign does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State law and Federal Law. This consent need only be obtained one time for all subsequent care given the patient in this office.

Name ________________________________ Signed: ___________________________________ Date: _____________
(Print Name) (Patient/Parent/Guardian Signature)

Must be signed by a parent or guardian if patient is a minor or under a guardianship order as defined by State law:

Doctor ________________________
Date ____/_____/20____ Patient Name______________________________ Patient #_______

LIFE SPRING
CHIROPRACTIC

In Your own words, please tell is why your brought your child to us today:

____

____

____

____

____

____

Please list any other pertinent history, comments, concerns, history, or requests:

____

____

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For Doctor's Use:

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INFORMED CONSENT

PATIENT NAME: ________________________________ ID: ___________

To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The nature of the chiropractic adjustment:

The primary treatment used is spinal manipulative therapy. I may use my hands or a mechanical instrument to move your joints. That may cause an audible “pop” or “click,” much as you have experienced when you “crack” your knuckles. You may feel a sense of movement.

Analysis / Examination / Treatment:

As a part of the analysis, examination, and treatment, you are consenting to the following procedures:

spinal manipulative therapy	hot/cold therapy
range of motion testing	vital signs
muscle strength testing	basic neurological testing
palpation	EMS
orthopedic testing	ultrasound
postural analysis	radiographic studies

As with any healthcare procedure, there are certain complications that may arise during chiropractic manipulation and therapy. Some patients will feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

Complications to treatment may include but are not limited to: muscle strain, cervical myelopathy, costovertebral strains and separations, ultrasound burns, disc complications, dislocations, and fractures. Dislocations or fractures are rare occurrences and generally result from some underlying weakness of the bone, which I check for during the taking of your history and during examination and x-ray. Incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

Other treatment options for your condition may include:

-Self-administered, over-the-counter analgesics and rest
-Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers
-Hospitalization
-Surgery

If you chose to use one of the above noted “other treatment” options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated:

Remaining untreated may allow the formation of adhesions and reduce mobility, which may set up a pain reaction further reducing mobility and leading to progressing degenerative disc disease and nerve dysfunction. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE. PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW

I understand the above explanation of the chiropractic adjustment and related treatment. I understand that I am always free to ask any additional questions that I may have. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Patient’s Name ________________________________

Signature ______________________________________ Date ___________

Signature of Parent or Guardian (if a minor) ___________________________

Witness____

Signature ______________________________________ Date___________