LIFE SPRING
CHIROPRACTIC

Office use:
Patient #_____
Account Date_____

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

Patient Information

Patient's Name: _____
(First) (MI) (Last)
Goes by name: _____

❑Male ❑Female Birth Date: ____/____/_____ Age: _____
SSN: _____-____-_____
Marital Status: ❑Married ❑Single ❑Separated ❑Divorced ❑Widowed

Address: _____
_____
(City) (State) (Zip)
Email: _____
Phone Numbers: Cell: (_____)_____
Home: (_____)_____
Work: (_____)_____
(**Please circle the best number to reach you**)
Work Status:
❑Employed ❑Unemployed ❑Student ❑Retired ❑Other _____
Occupation: _____
Employer: _____

Spouse Name: _____ Spouse Birthdate:_____
Spouse Employer: _____

Whom may we thank for referring you? _____

Emergency Contact:
Name:_____ Relationship to you: _____
Home phone: _____ Work phone: _____

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 understand that I may be contacted by Life Spring Chiropractic by phone, text, or email.

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 the subscriber 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

Main reasons for today's visit: _____

What treatment have your already received for your condition?
❑Medications ❑Surgery ❑Physical Therapy ❑Chiropractic ❑None
❑Other _____

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)

Is this condition due to an accident?
❑No ❑Yes Date of accident _____
Type of accident: ❑Auto ❑Work ❑Home
❑Other _____

Change in bodily function:
❑Coughing ❑Menstural ❑Urination ❑Bowel Habits
❑Gait ❑Sexual ❑Visual ❑Breathing ❑Grip ❑Sleep
❑Weakness ❑Coordination ❑Hearing ❑Sneezing
❑Weight

Handedness ❑Right ❑Left ❑Ambidexterous

Are you Pregnant? _____
Estimated Due Date: _____
Are you attempting to achieve pregnancy? _____
Date of last menstrual period: _____

See Next Page ➔

Exercise

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

Work Activity

- ❑ Computer
- ❑ Sitting
- ❑ Standing
- ❑ Light Labor
- ❑ Heavy Labor

Habits

- ❑Smoking Packs/day_____
- ❑Alcohol Drinks/week_____
- ❑Coffee/Caffeinated drinks Cups/day _____
- ❑High Stress Level Reason _____

Please indicate if you have had any of the following conditions:

- ❑ Headaches
- ❑ Neck Pain/Stiff Neck
- ❑ Asthma/Allergies
- ❑ Sleeping Problems
- ❑ Back Pain
- ❑ Nervousness
- ❑ Tension
- ❑ Irritability
- ❑ Chest Pains/Tightness
- ❑ Dizziness
- ❑ Shoulder/Neck/Arm Pain
- ❑ Numbness in Fingers
- ❑ Numbness in Toes
- ❑ High/Low Blood Pressure
- ❑ Ulcers
- ❑ Herniated Disc
- ❑ Breathing Problems
- ❑ Fatigue
- ❑ Lights Bother Eyes
- ❑ Ears Ringing
- ❑ Broken Bones
- ❑ Fractures
- ❑ Rheumatoid Arthritis
- ❑ Excessive Bleeding
- ❑ Osteoarthritis
- ❑ Pacemaker
- ❑ Stroke
- ❑ Spinal Disc Problems
- ❑ Eating Disorder
- ❑ Loss of Balance
- ❑ Fainting
- ❑ Loss of Smell
- ❑ Loss of Taste
- ❑ Unusual Bowel
- ❑ Drug Addiction
- ❑ Weakness in Arms/Legs
- ❑ Arthritis
- ❑ Muscle Spasms
- ❑ Frequent Colds
- ❑ Gall Bladder Problems
- ❑ Recurring Fever
- ❑ Sinus Problems
- ❑ Diabetes
- ❑ Indigestion
- ❑ Joint Pain/Swelling
- ❑ Menstrual Difficulty
- ❑ Miscarriage
- ❑ Weight Loss/Gain
- ❑ Depression
- ❑ Loss of Memory
- ❑ HIV Positive
- ❑ Circulation Problems
- ❑ Seizures/Epilepsy
- ❑ Digestive Problems
- ❑ Osteoporosis
- ❑ Heart Disease
- ❑ Cancer
- ❑ Alcoholism
- ❑ 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	Sib-lings
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							

Injuries/Surgeries you've had:

	Description	Date
Falls	_____	_____
Head Injuries	_____	_____
Broken Bones	_____	_____
Dislocations	_____	_____
Surgeries	_____	_____

Medications:

_____

_____

Supplements/Vitamins/Herbs, etc:

_____

_____

Allergies:

_____

_____

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's or Authorized person's signature)

Doctor _____
Date ____/_____/20____ Patient Name_____ Patient #_____

LIFE SPRING CHIROPRACTIC

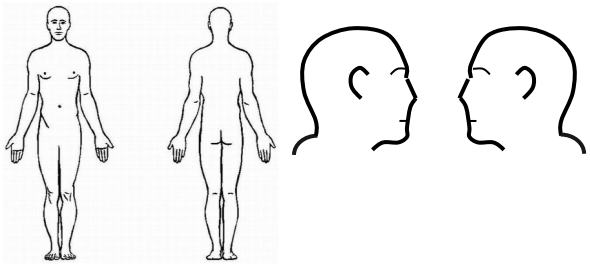
Nothing makes us happier than when we get to help patients prevent problems and protect their performance. Please happily check the "wellness box" if you are without symptoms. ☺ ☐

This flow chart gives the doctor a visual way of seeing what is bothering you. Please fill out what you can.

1

Mark an X where this symptom is:

Front Back Right Left



Name this symptom: _____

When did symptom start?
_____

How did it start? _____
_____
_____
_____

How frequently does it bother you?
❑Constant ❑Daily ❑Weekly
❑Monthly ❑Intermitted
❑Erratic ❑Other _____

What does it feel like?
❑Sharp ❑Shooting
❑Dull ❑Aching
❑Numb ❑Tingling
❑Burning ❑Stiffness
❑Other _____
_____
Does it Radiate down arms or legs ?_____
_____

Since onset, symptoms have:
❑Increased
❑Decreased
❑Remained the same
❑Erratic
❑Other _____

What makes it better? (example: certain time of day, position, medication, ice/heat, etc)
_____
_____

What makes it worse? (example: certain time of day, position, activities, etc.)
_____
_____
_____

What store bought or home remedies have you tried?
_____
_____
_____
_____
Effect? _____
_____
_____
Other professional care: ___
_____
_____
_____
Same or similar condition in the past? _____
_____

How are your day-to-day activities affected by this symptom?
_____
_____
_____
_____

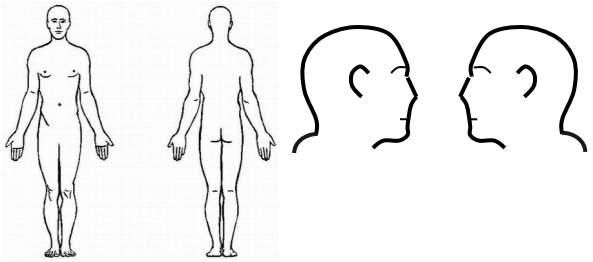
Notes: _____
_____

On a 1-10 scale, what low end/high end range does your symptom bother you?
1 2 3 4 5 6 7 8 9 10
_____

2

Mark an X where this symptom is:

Front Back Right Left



Name this symptom: _____

When did symptom start?
_____

How did it start? _____
_____
_____
_____

How frequently does it bother you?
❑Constant ❑Daily ❑Weekly
❑Monthly ❑Intermitted
❑Erratic ❑Other _____

What does it feel like?
❑Sharp ❑Shooting
❑Dull ❑Aching
❑Numb ❑Tingling
❑Burning ❑Stiffness
❑Other _____
_____
Does it Radiate down arms or legs ?_____
_____

Since onset, symptoms have:
❑Increased
❑Decreased
❑Remained the same
❑Erratic
❑Other _____

What makes it better? (example: certain time of day, position, medication, ice/heat, etc)
_____
_____

What makes it worse? (example: certain time of day, position, activities, etc.)
_____
_____
_____

What store bought or home remedies have you tried?
_____
_____
_____
_____
Effect? _____
_____
_____
Other professional care: ___
_____
_____
_____
Same or similar condition in the past? _____
_____

How are your day-to-day activities affected by this symptom?
_____
_____
_____
_____

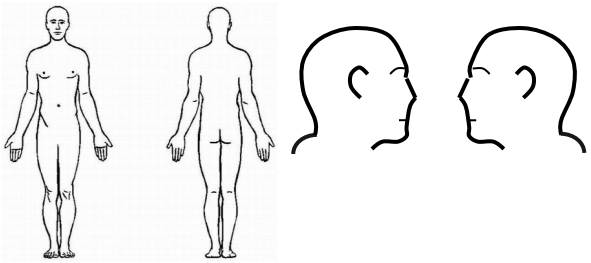
Notes: _____
_____

On a 1-10 scale, what low end/high end range does your symptom bother you?
1 2 3 4 5 6 7 8 9 10
_____

3

Mark an X where this symptom is:

Front Back Right Left



Name this symptom: _____

When did symptom start?
_____

How did it start? _____
_____
_____
_____

How frequently does it bother you?
❑Constant ❑Daily ❑Weekly
❑Monthly ❑Intermitted
❑Erratic ❑Other _____

What does it feel like?
❑Sharp ❑Shooting
❑Dull ❑Aching
❑Numb ❑Tingling
❑Burning ❑Stiffness
❑Other _____
_____
Does it Radiate down arms or legs ?_____
_____

Since onset, symptoms have:
❑Increased
❑Decreased
❑Remained the same
❑Erratic
❑Other _____

What makes it better? (example: certain time of day, position, medication, ice/heat, etc)
_____
_____

What makes it worse? (example: certain time of day, position, activities, etc.)
_____
_____
_____

What store bought or home remedies have you tried?
_____
_____
_____
_____
Effect? _____
_____
_____
Other professional care: ___
_____
_____
_____
Same or similar condition in the past? _____
_____

How are your day-to-day activities affected by this symptom?
_____
_____
_____
_____

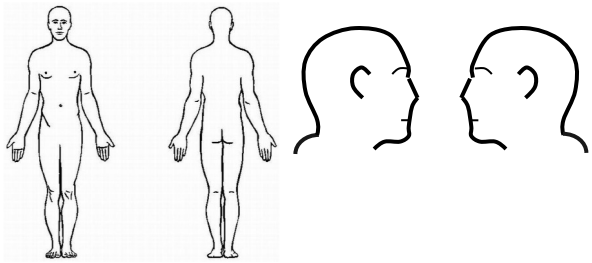
Notes: _____
_____

On a 1-10 scale, what low end/high end range does your symptom bother you?
1 2 3 4 5 6 7 8 9 10
_____

4

Mark an X where this symptom is:

Front Back Right Left



Name this symptom: _____

When did symptom start?
_____

How did it start? _____
_____
_____
_____

How frequently does it bother you?
❑Constant ❑Daily ❑Weekly
❑Monthly ❑Intermitted
❑Erratic ❑Other _____

What does it feel like?
❑Sharp ❑Shooting
❑Dull ❑Aching
❑Numb ❑Tingling
❑Burning ❑Stiffness
❑Other _____
_____
Does it Radiate down arms or legs ?_____
_____

Since onset, symptoms have:
❑Increased
❑Decreased
❑Remained the same
❑Erratic
❑Other _____

What makes it better? (example: certain time of day, position, medication, ice/heat, etc)
_____
_____

What makes it worse? (example: certain time of day, position, activities, etc.)
_____
_____
_____

What store bought or home remedies have you tried?
_____
_____
_____
_____
Effect? _____
_____
_____
Other professional care: ___
_____
_____
_____
Same or similar condition in the past? _____
_____

How are your day-to-day activities affected by this symptom?
_____
_____
_____
_____

Notes: _____
_____

On a 1-10 scale, what low end/high end range does your symptom bother you?
1 2 3 4 5 6 7 8 9 10
_____

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. We may use 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. We 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 out attention, it is your responsibility to inform us.

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 we check for during the taking of your history and during examination and x-ray. The other complications are also generally described as rare.

There are reported cases of stroke associated with neck movements including adjustments of the upper cervical spine. Current medical and scientific evidence does not establish a definite cause and effect relationship between upper cervical spine adjustment and the occurrence of stroke. Furthermore, the apparent association is noted very infrequently. However, you are being warned of this possible association because a stroke may cause serious neurological impairment and result in injuries including paralysis.

Common alternatives to adjustments and manipulations include medications, physical therapy, other medical treatments and surgery provided by physicians and surgeons.

If you chose to use one of the above noted alternative 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.

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

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_____