



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 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 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 _____ Stand Alone

_____ Respond to Visual Stimuli _____ Cross Crawl

_____ Hold Head Up _____ Walk Alone

_____ Sit Up

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 Heavy book bag/backpack
 Sitting Very Active/Sports
 Standing

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

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

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 our 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 choose 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 _____

