

**PATIENT DEMOGRAPHICS**

Today's Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

PMID#: \_\_\_\_\_

Child's Name: \_\_\_\_\_ Birth Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age: \_\_\_\_\_  Male  Female

Birth Height: \_\_\_\_\_ Birth Weight: \_\_\_\_\_ Current Height: \_\_\_\_\_ Current Weight: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Family E-mail: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Mother's Name: \_\_\_\_\_ DOB \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Mother's Mobile: \_\_\_\_\_

Father's Name: \_\_\_\_\_ DOB \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Father's Mobile: \_\_\_\_\_

Pediatrician/Family MD \_\_\_\_\_ City/State \_\_\_\_\_

Last Visit: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Reason for visit? \_\_\_\_\_

Who is responsible for this bill? \_\_\_\_\_

Other (please explain): \_\_\_\_\_

**CHILD'S CURRENT PROBLEM**

**Purpose of this visit:**  Wellness Check-up  Injury or Accident  Other (please explain): \_\_\_\_\_

If your child is experiencing **Pain/Discomfort**, please identify where and for how long this has been going on

1. **When did** the problem first begin? Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  Unknown  Gradual  Sudden
  2. **Ever had** this problem **before**?  No  Yes If yes, when? \_\_\_\_\_
  3. Any **bowel or bladder** problems since this problem began?  No  Yes If yes, describe: \_\_\_\_\_
  4. Have you seen any **other doctors** for this problem?  No  Yes If yes, who?: \_\_\_\_\_
  5. **How long ago** did you see someone for this problem?  Days  Weeks  Months  Years
  6. What were the **results** of the past treatment? \_\_\_\_\_
  7. How is this problem **NOW**?  Rapidly Improving  Improving Slowly  About the Same  Gradually Worsening  On & Off
  8. Please list any **medication taken** for this problem: \_\_\_\_\_
  9. Has your child ever sustained any **injuries** playing organized sports?  No  Yes If yes, please explain: \_\_\_\_\_
- 
10. Has your child ever sustained an injury in an auto accident? Yes If yes, please explain: \_\_\_\_\_

**HAS YOUR CHILD EVER SUFFERED FROM: (Check all that apply)**

- |   |   |   |  |  |
|---|---|---|--|--|
| <input type="checkbox"/> Headache                 | <input type="checkbox"/> Orthopedic Problems    | <input type="checkbox"/> Broken Bones         | <input type="checkbox"/> Colds/Flu           | <input type="checkbox"/> Sleeping Problems |
| <input type="checkbox"/> Dizziness                | <input type="checkbox"/> Neck Problems          | <input type="checkbox"/> Fall off slide       | <input type="checkbox"/> Behavioral Problems | <input type="checkbox"/> Fall off swing    |
| <input type="checkbox"/> Fainting                 | <input type="checkbox"/> Arm Problems           | <input type="checkbox"/> Fall from crib       | <input type="checkbox"/> ADD/ADHD            | <input type="checkbox"/> Fall down stairs  |
| <input type="checkbox"/> Seizures                 | <input type="checkbox"/> Leg Problems           | <input type="checkbox"/> Poor Appetite        | <input type="checkbox"/> Ruptures/Hernia     |  |
| <input type="checkbox"/> Convulsions              | <input type="checkbox"/> Joint Problems         | <input type="checkbox"/> Stomach Aches        | <input type="checkbox"/> Muscle Pains        |  |
| <input type="checkbox"/> Heart Trouble            | <input type="checkbox"/> Backaches              | <input type="checkbox"/> Reflux               | <input type="checkbox"/> Growing Pains       |  |
| <input type="checkbox"/> Chronic Earaches         | <input type="checkbox"/> Poor Posture           | <input type="checkbox"/> Constipation         | <input type="checkbox"/> Asthma              |  |
| <input type="checkbox"/> Sinus Trouble            | <input type="checkbox"/> Anemia                 | <input type="checkbox"/> Hypertension         | <input type="checkbox"/> Walking Trouble     |  |
| <input type="checkbox"/> Scoliosis                | <input type="checkbox"/> Colic                  | <input type="checkbox"/> Fall off skateboard  |  |  |
| <input type="checkbox"/> Bed Wetting              | <input type="checkbox"/> Fall from bed or couch | <input type="checkbox"/> Fall from high chair |  |  |
| <input type="checkbox"/> Fall in baby walker      |   | <input type="checkbox"/> Digestive Problems   |  |  |
| <input type="checkbox"/> Fall from changing table |   | <input type="checkbox"/> Fall off monkey bars |  |  |

Allergies to \_\_\_\_\_

Other: \_\_\_\_\_



## TERMS OF ACCEPTANCE

In order to provide the most effective healing environment, most effective application of chiropractic procedures, and the strongest possible doctor-patient relationship, it is our wish to provide each patient with a set of parameters and declarations that will facilitate the goal of optimum health through chiropractic.

To that end, we ask that you acknowledge the following points regarding chiropractic care and the services that are offered through this clinic:

- A. Chiropractic is a very specific science, authorized by law to address spinal health concerns and needs. Chiropractic is a separate and distinct science, art and practice. It is not the practice of medicine.
- B. Chiropractic seeks to maximize the inherent healing power of the human body by restoring normal nerve functions through the adjustment of spinal subluxation(s). Subluxations are deviations from normal spinal structures and configurations that interfere with normal nerve processes.
- C. The chiropractic adjustment process, as defined in the law of this jurisdiction, involves the application of a specific directional thrust to a region or regions of the spine with the specific intent of re-positioning misaligned spinal segments. This is a safe, effective procedure applied over one million times each day by doctors of chiropractic in the United States alone.
- D. A thorough chiropractic examination and evaluation is part of the standard chiropractic procedure. The goal of this process is to identify any spinal health problems and chiropractic needs. If during this process, any condition or question outside the scope of chiropractic is identified, you will receive a prompt referral to an appropriate provider or specialist, according to the initial indications of the need.
- E. Chiropractic does not seek to replace or compete with your medical, dental or other type(s) of health professionals. They retain responsibility for care and management of medical conditions. We do not offer advice regarding treatment prescribed by others.
- F. Your compliance with care plans, home and self-care, etc., is essential to maximum healing and optimal health.
- G. We invite you to speak frankly to the doctor on any matter related to your care at this facility, its nature, duration, or cost, in what we work to maintain as a supporting, open environment.

I hereby authorize payment to be made directly to Life Force Chiropractic for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to Life Force Chiropractic for any and all services I receive at this office.

By my signature below, I have read and fully understand the above statements.

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my satisfaction. I therefore accept chiropractic care on this basis.

\_\_\_\_\_  
Patient or Authorized Person's Signature

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date Completed

\_\_\_\_\_  
Life Force Representative Signature

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date Form Reviewed

## LIFE FORCE CHIROPRACTIC OF PRIVACY PRACTICE

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your Personal Health Information. In addition, we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or as **dictated by our office policy**, we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. In addition, you will find we have placed several copies in report folders labeled 'HIPAA' on tables in the reception area. Once you have read this notice, please sign the last page, and return to our front desk receptionist. Keep this page for your records.

### PERMITTED DISCLOSURES:

1. Treatment purposes – discussion with other health care providers in your care.
2. Inadvertent disclosures – open treating area means open discussion. If you need to speak privately to the doctor, please let our staff know so we can place you in a private consultation room.
3. For payment purposes – to obtain payment from your insurance company or any other collateral source.
4. For workers compensation – to process a claim or aid in investigation.
5. Emergency – in the event of emergency we may notify a family member.
6. For public health and safety – in order to prevent or lessen a serious or eminent threat to the health or safety of a person or general public.
7. To government agencies or Law enforcement – to identify or locate a suspect, fugitive, material witness or missing person.
8. For military, national security, prisoner and government purposes.
9. Deceased persons – discussion with coroners and medical examiners in the event of a patient's death.
10. Telephone calls or emails and appointment reminders – **we may call your home and leave messages** regarding a missed appointment or apprise you of changes in practice hours or upcoming events.
11. Change of ownership – in the event this practice is sold the new owners would have access to your PHI.

### YOUR RIGHTS:

1. To receive an accounting of disclosures.
2. To receive a paper copy of the comprehensive "Detail" Privacy Notice.
3. To request mailings to an address different than residence.
4. To request Restriction on certain uses and disclosures and with whom we release information to, although we are not required to comply. If, however, we agree, the restriction will be in place until written notice of your intent to remove the restriction.
5. To inspect your records and receive one copy of your records at no charge, with notice in advance.
6. To request amendments to information. However, like restriction, we are not required to agree with them.
7. To obtain **one copy** of your records at no charge, when timely notice is provided (72 hours). At your request, we will provide you with a copy of your x-rays in our files. **The fee for copying your x-rays on a disc is \$15.00. This fee must be paid in advance.** *(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 doctor does 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).*

I have received a copy of Life Force Chiropractic Patient Privacy Notice. I understand my rights as well as the practice's duty to protect my health information, and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this "Notice of Privacy Practice" at a time in the future and will make the new provisions effective for all information that it maintains past and present.

I am aware that a more comprehensive version of this "Notice" is available to me and several copies kept in the reception area. At this time, I do not have any questions regarding my rights or any of the information I have received.

\_\_\_\_\_  
Patient or Authorized Person's Signature

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date

**MEDICAL INFORMATION RELEASE FORM (HIPAA RELEASE)**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

***Release of Information:***

I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

Spouse\_\_\_\_\_

Child(ren)\_\_\_\_\_

Other\_\_\_\_\_

Information is not to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by me in writing.

Signed: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**CLINICAL EXAM FINDINGS – \*This page for office use only\***

- Subluxation/Palp:**
- C1
  - C2
  - C3
  - C4
  - C5
  - C6
  - C7
  - T1
  - T2
  - T3
  - T4
  - T5
  - T6
  - T7
  - T8
  - T9
  - T10
  - T11
  - T12
  - L1
  - L2
  - L3
  - L4
  - L5
  - LSI
  - RSI
  - SAC

Cervical	0%	25%	50%	75%	100%	Pain
Flexion	<input type="checkbox"/>					
Extension	<input type="checkbox"/>					
L Lat Flex	<input type="checkbox"/>					
R Lat Flex	<input type="checkbox"/>					
L Rotation	<input type="checkbox"/>					
R Rotation	<input type="checkbox"/>					
Thoracic	0%	25%	50%	75%	100%	Pain
Flexion	<input type="checkbox"/>					
L Rotation	<input type="checkbox"/>					
R Rotation	<input type="checkbox"/>					
Lumbar	0%	25%	50%	75%	100%	Pain
Flexion	<input type="checkbox"/>					
Extension	<input type="checkbox"/>					
L Lat Flex	<input type="checkbox"/>					
R Lat Flex	<input type="checkbox"/>					

**Posture:**

FHP + -

Head Tilt R L

Head Rotation R L

High Shoulder R L

Thoracic Tilt R L

Thoracic Rotation R L

High Hip R L

Foot Flare R L

Short Leg R L

Notes:

**Infants & Newborns:**

Rooting Reflex: Y N  
*Cheeks*

Grasp Reflex: Y N  
*Palms of hands*

Moro Response: Y N  
*Loud noises*

Sleeping (# of hrs/day): \_\_\_\_\_

Pooping (# of times/day): \_\_\_\_\_

Feeding: # of times/day \_\_\_\_\_  
Frequency: \_\_\_\_\_

\_\_\_\_\_  
Doctor/Examiner Signature

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date