



**CHILD APPLICATION FOR CARE**  
**Life Force Chiropractic**  
 1825 SE 164th Ave. #118  
 Vancouver, WA  
 (360) 524-7677

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

Name: \_\_\_\_\_ Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Male / Female Social Security Number: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Guardian(s) Name(s): \_\_\_\_\_ Relationship: \_\_\_\_\_

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

Phone: Home ( ) \_\_\_\_\_ Work ( ) \_\_\_\_\_ Cell ( ) \_\_\_\_\_

Email Address: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone #: \_\_\_\_\_

Does your child have insurance?  Yes  No Primary Insurance: \_\_\_\_\_

Secondary Ins.: \_\_\_\_\_ Name of Insured: \_\_\_\_\_

Whom may we thank for referring you to our office?: \_\_\_\_\_

**YOUR HEALTH HISTORY**

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

- |  |   |   |   |   |
|--|---|---|---|---|
| <input type="checkbox"/> Headaches           | <input type="checkbox"/> Ear Infections       | <input type="checkbox"/> Sinus Issues         | <input type="checkbox"/> Kidney Problems      | <input type="checkbox"/> Numb/Tingling Arms/Hands (L/R) |
| <input type="checkbox"/> Migraines           | <input type="checkbox"/> Hearing Loss         | <input type="checkbox"/> Frequent Colds       | <input type="checkbox"/> Colic                | <input type="checkbox"/> Numb/Tingling Legs/Feet (L/R)  |
| <input type="checkbox"/> Jaw/TMJ Pain        | <input type="checkbox"/> Ringing in the Ears  | <input type="checkbox"/> Thyroid Issues       | <input type="checkbox"/> Torticollis          | <input type="checkbox"/> Allergies                      |
| <input type="checkbox"/> Neck Pain           | <input type="checkbox"/> Dizziness            | <input type="checkbox"/> Asthma               | <input type="checkbox"/> Autism               | <input type="checkbox"/> Behavioral Issues              |
| <input type="checkbox"/> Shoulder Pain (L/R) | <input type="checkbox"/> Loss of Energy       | <input type="checkbox"/> Difficulty Breathing | <input type="checkbox"/> Sensory Issues       | <input type="checkbox"/> Mood Swings                    |
| <input type="checkbox"/> Elbow/Wrist Pain    | <input type="checkbox"/> Sleep Problems       | <input type="checkbox"/> Nausea               | <input type="checkbox"/> Seizures             | <input type="checkbox"/> Excessive Tantrums             |
| <input type="checkbox"/> Upper Back Pain     | <input type="checkbox"/> Double/Blurry Vision | <input type="checkbox"/> Ulcers               | <input type="checkbox"/> Epilepsy/Convulsions | <input type="checkbox"/> Reflux                         |
| <input type="checkbox"/> Mid Back Pain       | <input type="checkbox"/> Anxiety              | <input type="checkbox"/> Stomach Issues       | <input type="checkbox"/> Tremors              | <input type="checkbox"/> Heart Problems                 |
| <input type="checkbox"/> Lower Back Pain     | <input type="checkbox"/> Nervousness          | <input type="checkbox"/> Digestive Issues     | <input type="checkbox"/> Disc problems        | <input type="checkbox"/> Cancer                         |
| <input type="checkbox"/> Hip/Leg Pain (L/R)  | <input type="checkbox"/> Depression           | <input type="checkbox"/> Diarrhea             | <input type="checkbox"/> Scoliosis            | <input type="checkbox"/> Spinal Bone Fracture           |
| <input type="checkbox"/> Sciatic Pain (L/R)  | <input type="checkbox"/> Loss of Balance      | <input type="checkbox"/> Constipation         | <input type="checkbox"/> Poor Posture         | <input type="checkbox"/> Spinal Surgery                 |
| <input type="checkbox"/> Knee (L/R)          | <input type="checkbox"/> ADD/ADHD             | <input type="checkbox"/> Bed Wetting          | <input type="checkbox"/> Skin Problems        | <input type="checkbox"/> Diabetes (Type 1 or 2)         |
| <input type="checkbox"/> Foot (L/R)          | <input type="checkbox"/> Arthritis/Joint Pain | <input type="checkbox"/> Bladder Problems     | <input type="checkbox"/> Other: _____         |   |

**Main Complaint:** \_\_\_\_\_

List any medications presently taking: \_\_\_\_\_

Has your child been in a car accident recently? Yes No If so, when?: \_\_\_\_\_

The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine my child for further evaluation.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 (if under 18 years)

**To be filled out by Parent/Guardian about Pregnancy of the Child Listed Above:**

How was your pregnancy? \_\_\_\_\_

Any Pregnancy Complications? \_\_\_\_\_

Did you take any medication during your pregnancy? \_\_\_\_\_

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

**Delivery Information:**

Location of Birth: (circle one)      Hospital      Birth Center      Home      Other: \_\_\_\_\_

Birth Intervention: (circle one)      Induction      Forceps      Vacuum Extraction      Caesarean section

Induced? Yes / No Explain: \_\_\_\_\_

Medications during delivery? \_\_\_\_\_

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

**Post Birth Information:**

Birth Weight: \_\_\_\_\_ Birth Length: \_\_\_\_\_

Breast Fed: Yes / No How long? \_\_\_\_\_ Formula Fed: Yes / No How Long? \_\_\_\_\_

Introduced Solid Foods at \_\_\_\_\_ months

Food Allergies or intolerances: \_\_\_\_\_

Doses of antibiotics/prescription drugs your child has taken: Past 6 months \_\_\_\_\_ Lifetime \_\_\_\_\_

Over the counter drugs (Tylenol, Cough Syrup, Laxatives, etc.) \_\_\_\_\_

List all Surgical operations / hospitalizations / slips/falls and year of occurrence: \_\_\_\_\_

Has your child ever been knocked unconscious?  Yes  No      Fractured a bone?  Yes  No

If yes to either of the above, please describe: \_\_\_\_\_

Does your child have difficulty turning their head?  Yes  No If yes, which way? \_\_\_\_\_

Does your child arch their neck/back or have involuntary movements or restriction with movements? \_\_\_\_\_

**Activities of Life**

Please identify how your child's current condition is affecting their ability to carry out activities that are routinely part of their life or milestones they are struggling to meet.

List Restricted Activity	Current Activity Level	Usual Activity Level
Example: Crawling all around	Not crawling hardly at all	They used to be able to crawl no problem
_____	_____	_____
_____	_____	_____
_____	_____	_____

## Quadruple Visual Analogue Scale

Please **circle** the number that best describes the question asked for your **MAIN COMPLAINT**.

1. How would you rate your pain **RIGHT NOW**?

No pain \_\_\_\_\_ Worst Possible Pain  
0 1 2 3 4 5 6 7 8 9 10

2. What is your typical **AVERAGE** pain?

No pain \_\_\_\_\_ Worst Possible Pain  
0 1 2 3 4 5 6 7 8 9 10

3. What is your pain level at its **BEST**? (How close to 0 does your pain get at its best?)

No pain \_\_\_\_\_ Worst Possible Pain  
0 1 2 3 4 5 6 7 8 9 10

4. What is your pain level at its **WORST**? (How close to 10 does your pain get at its worst?)

No pain \_\_\_\_\_ Worst Possible Pain  
0 1 2 3 4 5 6 7 8 9 10

## **Notice of Privacy Practices Acknowledgement**

I understand that I have certain rights of privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

1. Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations, such as quality assessments and physicians certifications.

I acknowledge that I may request your NOTICE OF PRIVACY PRACTICES containing a more complete description of the uses and disclosures of my health information. I also understand that I may request, in writing, that you restrict how my private information is used to disclose to carry out treatment, payment, or healthcare operation. I also understand you are not required to agree to my requested restrictions, but if you agree, then you are bound to abide by such restrictions.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(if under 18 years)

### **Release of Information:**

I authorize the release of information including the diagnosis, records; examination rendered to my child, 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.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(if under 18 years)

## Informed Consent For Chiropractic Care

Chiropractic care, like all forms of health care while offering considerable benefits may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases, injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include: sprain/strain injuries, irritation of a disc condition, and rarely, fractures. One of the rarest complications associated with chiropractic care occurring at a rate between one instance per one million to one per two million cervical spine (neck) adjustments may be a vertebral injury that could lead to a stroke.

Prior to receiving chiropractic care in the chiropractic office, a health history and physical examination will be completed. These procedures are performed to assess your specific conditions, your overall health and in particular your spinal health. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies are needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan prior to beginning care.

- I understand and accept that there are risks associated with chiropractic care and give consent to the examination that the doctor deems necessary and the chiropractic care, including spinal adjustments, as reported following my assessment.
- I authorize and request payment of insurance benefits directly to Cody Kurscheidt, Kyle Kurscheidt, & Tiffany Thorne, D.C. I agree that this authorization will cover all services rendered until I revoke the authorization. I agree that a photocopy of this form may be used in place of the original. All professional services rendered are charged to the patient. It is customary to pay for services when rendered unless other arrangements have been made in advance. I understand that I am financially responsible for charges not covered by this assignment.

Print Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### If This Health Profile Is For A Minor/Child, Please Fill Out And Sign Below Written Consent For A Child

Name of patient who is a minor/child: \_\_\_\_\_

I authorize Dr. Cody Kurscheidt, Dr. Kyle Kurscheidt, & Dr. Tiffany Thorne and any and all Life Force Chiropractic staff to perform diagnostic procedures, radiographic evaluations, render chiropractic care, and perform chiropractic adjustments to my minor/child. As of this date, I have the legal right to select and authorize health care services for my minor/child. If my authority to select and authorize care is revoked or altered, I will immediately notify Life Force Chiropractic.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to Minor/Child: \_\_\_\_\_

### X-Ray Authorization

As your healthcare provider, we are legally responsible for your chiropractic records. We must maintain a record of your x-rays in our files. At your request, we will provide you with a copy of your x-rays in our files for a fee of \$15 per copy (1st copy at no charge). Copy of x-rays are burned to a CD and available for pick up within 72hrs of payment, during normal business hours.

**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(s) of Life Force Chiropractic 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.

By signing below you are agreeing to the above terms and conditions.

Print Full Legal Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(if under 18 years)

**FEMALES ONLY:** To the best of my knowledge, **I BELIEVE I AM NOT PREGNANT** at the time the x-rays are taken at Life Force Chiropractic.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_