LIFE FORCE
CHIROPRACTIC

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)

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