

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 you 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: _____
 Name of office/practice: _____ City: _____

Name of other professionals with whom you've sought care for this condition:

 Name of office/practice: _____ City: _____

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 Menstrual 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: _____

Exercise <input type="checkbox"/> None <input type="checkbox"/> Light <input type="checkbox"/> Moderate <input type="checkbox"/> Heavy	Work Activity <input type="checkbox"/> Computer <input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Light Labor <input type="checkbox"/> Heavy Labor	Habits <input type="checkbox"/> Smoking Packs/day _____ <input type="checkbox"/> Alcohol Drinks/week _____ <input type="checkbox"/> Coffee/Caffeinated drinks Cups/day _____ <input type="checkbox"/> High Stress Level Reason _____
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Please indicate if you have had any of the following conditions:

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

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)

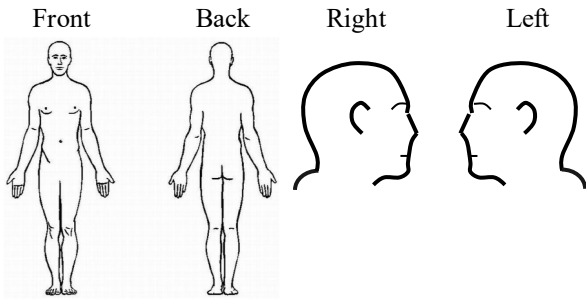
Doctor _____
 Date ____/____/20____ Patient Name _____ Patient # _____

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:



Name this symptom: _____

When did symptom start?

 How did it start? _____

 How frequently does it bother you?
 Constant Daily Weekly
 Monthly Intermittent
 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?

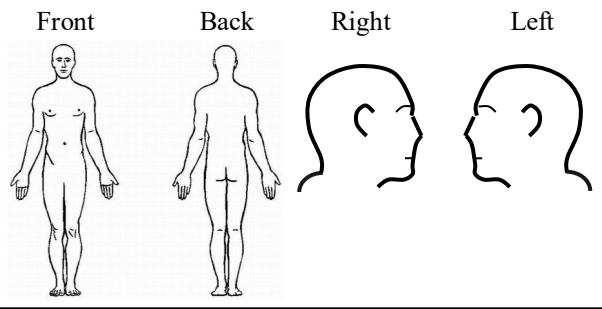
How are your day-to-day activities affected by this symptom?

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:



Name this symptom: _____

When did symptom start?

 How did it start? _____

 How frequently does it bother you?
 Constant Daily Weekly
 Monthly Intermittent
 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?

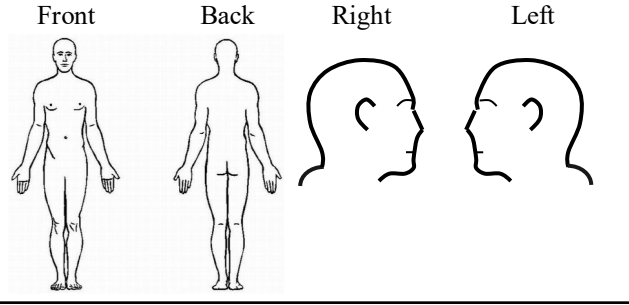
How are your day-to-day activities affected by this symptom?

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:



Name this symptom: _____

When did symptom start?

How did it start? _____

How frequently does it bother you?
 Constant Daily Weekly
 Monthly Intermittent
 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.)

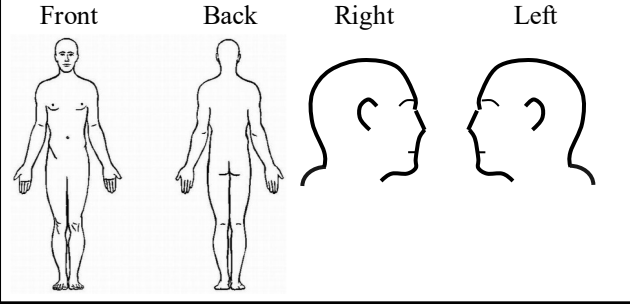
How are your day-to-day activi-
 ties affected by this symptom?

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:



Name this symptom: _____

When did symptom start?

How did it start? _____

How frequently does it bother you?
 Constant Daily Weekly
 Monthly Intermittent
 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.)

How are your day-to-day activi-
 ties 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 _____