



APPLICATION FOR CARE
Life Force Chiropractic
1825 SE 164th Ave. #118
Vancouver, WA 98683
(360) 524-7677

Today's Date: ____/____/____

Name: _____ Birth Date: ____/____/____ Age: ____

Height: _____ Weight: _____ Male / Female Social Security Number: ____ - ____ - ____

Address: _____ City: _____ State: ____ Zip: _____

Phone: Home () _____ Work () _____ Cell () _____

Email Address: _____

Occupation: _____ Emergency Contact Name: _____

Relationship of Emergency Contact to you: _____ Emergency Contact Phone Number: _____

Do you Have Insurance: Yes No Primary Insurance: _____

Secondary Ins.: _____ Name of Insured: _____

Single Divorced Widowed Married Spouse's Name: _____

Do you have children? Yes / No Names & Ages of Children: _____

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

YOUR HEALTH HISTORY

Please check all symptoms you have ever had, even if they do not seem related to your current problems

- | | | | | |
|--|---|---|---|---|
| <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"/> Menstrual Problems | <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"/> Prostate problems | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Asthma | <input type="checkbox"/> Sexual Dysfunction | <input type="checkbox"/> Heart Attack |
| <input type="checkbox"/> Shoulder Pain (L/R) | <input type="checkbox"/> Loss of Energy | <input type="checkbox"/> Difficulty Breathing | <input type="checkbox"/> Infertility | <input type="checkbox"/> Heart Problems |
| <input type="checkbox"/> Elbow/Wrist Pain | <input type="checkbox"/> Sleep Problems | <input type="checkbox"/> Nausea | <input type="checkbox"/> Seizures | <input type="checkbox"/> High/Low Blood Pressure |
| <input type="checkbox"/> Upper Back Pain | <input type="checkbox"/> Double/Blurry Vision | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Epilepsy/Convulsions | <input type="checkbox"/> GERD/Gastric Reflux |
| <input type="checkbox"/> Mid Back Pain | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Stomach Issues | <input type="checkbox"/> Tremors | <input type="checkbox"/> Chest Pain |
| <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"/> Allergies | <input type="checkbox"/> Bladder Problems | <input type="checkbox"/> Arthritis/Joint Pain | <input type="checkbox"/> Fibromyalgia |

Main Complaint: _____

List any medications you are taking: _____

Have you been in a car accident recently? Yes No If so, when?: _____

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

Patient Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

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.

Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

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.

Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

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. and 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. and 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. 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: _____