LIFE FORCE
CHIROPRACTIC

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?: _____

AUTO INFORMATION NEEDED FOR CARE

The following information is required to be seen for care following your personal injury or motor vehicle accident, if you wish to submit your care to a claim with an insurance company. This information is required upon your first visit to pursue an insurance claim regarding your injury.

- Valid Driver's License
- Police Report (If you don't have it yet, please bring it on your next visit)
- Health Insurance Card (If you have insurance)
- Auto Insurance Card
- Attorney Information (If one is involved)
- Accident claim number and the name and phone number of your medical adjuster

Patient Name:_____ Claim #: _____

Medical Adjuster:_____ Email for Adjuster:_____

Adjuster Phone Number:_____ Fax Number:_____

Insurance Company Name and Address:_____

_____

NATURE OF THE ACCIDENT

Please explain, in detail, how your accident happened:

_____

_____

_____

What were the time(s) and date(s) of your present injury?_____

Where did you feel pain immediately after the accident?_____

SYMPTOMS THAT WERE CREATED FROM THE ACCIDENT ONLY

Please ✔ check all symptoms you have noticed **since the accident**

___ Headaches	___ Numbness in Fingers	___ Constipation	___ Face is Flushed	___ Loss of Balance
___ Sensitive to light	___ Numbness in Toes	___ Loss of Smell	___ Tension	___ Nervousness
___ Head seems Heavy	___ Dizziness	___ Loss of Taste	___ Fever	___ Irritability
___ Pins/Needles in Arms	___ Buzzing in Ears	___ Depression	___ Chest Pains	___ Cold Sweats
___ Shoulder Pain (L/R)	___ Memory Loss	___ Diarrhea	___ Neck Pain	___ Shortness of Breath
___ Sleeping Problems	___ Ringing in Ears	___ Cold Feet	___ Neck Stiffness	___ Upset Stomach
___ Pins/Needles in Legs	___ Back Pain	___ Cold Hands	___ Fainting	___ Fatigue

INJURY RELATED QUESTIONS

Before the injury, were you capable of working on an equal basis with others your age? Yes / No

Are your work activities restricted as a result of this accident? Yes / No

Since this injury are your symptoms: Improving / Getting Worse / Staying the Same

Driver of the other vehicle(s) (If Any)

Name_____ Insurance Company_____ Policy #:_____

Driver of vehicle in which you were injured (If Applicable)

Name_____ Insurance Company _____ Policy #:_____

Name of your Insurance Adjuster:_____

Have you Retained an Attorney? Yes / No

Name of Attorney:_____ Address:_____

Location of Accident: _____

_____

Were police notified? Yes / No

Were you knocked unconscious? Yes / No If so, How long?_____

You were struck from: Behind / Front / Left Side / Right Side

You were the: Driver / Passenger / Front Seat / Back Seat /

Using Seatbelts? Yes / No

Patient Signature:_____ Date:_____

Doctor's Signature:_____ Date:_____

YOUR HEALTH HISTORY

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

___ Headaches	___ Ear Infections	___ Sinus Issues	___ Kidney Problems	___ Numb/Tingling Arms/Hands (L/R)
___ Migraines	___ Hearing Loss	___ Frequent Colds	___ Menstrual Problems	___ Numb/Tingling Legs/Feet (L/R)
___ Jaw/TMJ Pain	___ Ringing in the Ears	___ Thyroid Issues	___ Prostate problems	___ Stroke
___ Neck Pain	___ Dizziness	___ Asthma	___ Sexual Dysfunction	___ Heart Attack
___ Shoulder Pain (L/R)	___ Loss of Energy	___ Difficulty Breathing	___ Infertility	___ Heart Problems
___ Elbow/Wrist Pain	___ Sleep Problems	___ Nausea	___ Seizures	___ High/Low Blood Pressure
___ Upper Back Pain	___ Double/Blurry Vision	___ Ulcers	___ Epilepsy/Convulsions	___ GERD/Gastric Reflux
___ Mid Back Pain	___ Anxiety	___ Stomach Issues	___ Tremors	___ Chest Pain
___ 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)	___ Allergies	___ Bladder Problems	___ Arthritis/Joint Pain	___ Fibromyalgia

Main Complaint: _____

Did you ever experience the above complaint ***prior*** to your accident? Yes / No Please explain if you answered yes: _____

_____

List any medications you are taking: _____

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: _____

Please continue to the next page.

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. & 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: _____