

Lovett Chiropractic Pain Relief Clinic

REQUIRED FOR YOUR CASE HISTORY FILE

Date: _____

Name: _____ Date of Birth: _____ Sex: Male Female

Address: _____ City: _____ State: _____ Zip Code: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

Email Address: _____

Circle if you are: Married Single Widowed Divorced Number of Children: _____

Name of Spouse: _____ Employer: _____

Primary Insured Name/Responsible Party: _____ Date of Birth: _____

Insurance Carrier: _____ Primary Insured Name: _____

Emergency Contact: _____ Telephone: _____

On a scale of 0 to 10, please rate your pain for each of the following areas:

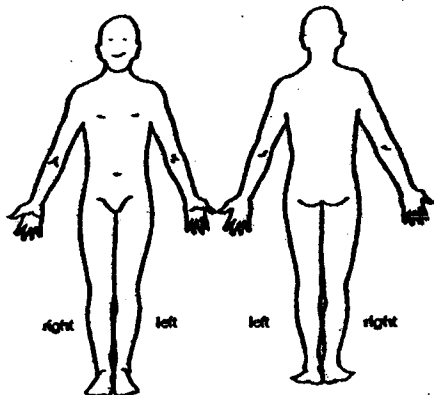
PAIN SCALE

Neck: _____ Shoulder/Arm: _____ Headaches: _____

0 1 2 3 4 5 6 7 8 9 10
NONE LITTLE MEDIUM SEVERE

Mid back: _____ Low back: _____ Leg: _____

Please mark where you are hurting on the body below:



MAIN COMPLAINT TODAY: _____

HOW LONG HAS THE PAIN BEEN THERE? _____

THE PAIN IS: (please circle all that apply)

- Numbness Tingling Pins & Needles Weakness Stabbing
 Aching Stiffness Throbbing Burning Radiating
 Sharp Dull Constant Comes & Goes

COMPLAINTS OTHER THAN ABOVE: _____

CHECK SYMPTOMS YOU HAVE NOTICED:

- | | | |
|---|---|---|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Numbness in Legs or Toes | <input type="checkbox"/> Pins & Needles in Arms |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Pins & Needles in Legs or Toes |
| <input type="checkbox"/> Neck Stiff | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Numbness in Fingers |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Depression | <input type="checkbox"/> Loss of Smell |
| <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Lights Bother Eyes | <input type="checkbox"/> Loss of Taste |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Loss of Memory | <input type="checkbox"/> Diarrhea/Constipation |
| <input type="checkbox"/> Tension | <input type="checkbox"/> Ears Ring | <input type="checkbox"/> Feet Cold |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Face Flushed | <input type="checkbox"/> Hands Cold |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Stomach Upset |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Buzzing in Ears | <input type="checkbox"/> Cold Sweats |
| <input type="checkbox"/> Head Seems Too Heavy | <input type="checkbox"/> Fainting | <input type="checkbox"/> Fever |

WHO CAN WE THANK FOR REFERRING YOU TO OUR OFFICE? _____

IF YOU ARE FEMALE, ARE YOU POSSIBLY PREGNANT? Yes No

SIGNATURE _____ DATE _____

REVIEW OF SYMPTOMS

LAST PHYSICAL EXAMINATION: _____

HAVE YOU BEEN TREATED BY A PHYSICIAN FOR ANY HEALTH CONDITION IN THE LAST YEAR? Yes No
 IF YES, EXPLAIN: _____

WHAT MEDICATIONS ARE YOU TAKING? _____

PREVIOUS SERIOUS ILLNESS: (Please list and describe): _____

FAMILY HISTORY OF: Heart Disease Cancer Diabetes Arthritis Back Problems Disc Problems Other

HAVE YOU EVER SUFFERED FROM:

Dizziness	Yes	No	Neuritis	Yes	No
Backaches	Yes	No	Digestive Disorders	Yes	No
Heart Trouble	Yes	No	Nervousness	Yes	No
Diabetes	Yes	No	Sinus Trouble	Yes	No
Tuberculosis	Yes	No	Rheumatic Fever	Yes	No
Arthritis	Yes	No	Anemia	Yes	No
Headaches	Yes	No	Cancer	Yes	No
Numbness	Yes	No	Kidney Trouble	Yes	No
Lung Problems	Yes	No	High Blood Pressure	Yes	No

IF YES, EXPLAIN _____

Functional Rating Index

In order to properly assess your condition, we must understand how much your problems have affected your ability to manage everyday activities. For each item below, please mark the number which most closely describes your condition now.

Without ANY difficulty – 0 with SOME difficulty – 1 MUCH difficulty – 2 UNABLE to do – 3

Dressing & Grooming

Are you able to:
 Dress yourself, including tying shoelaces and doing buttons? _____
 Shampoo your hair? _____
 Wash & dry your body? _____

Sitting/Standing

Are you able to:
 Sit or stand for more than 10 minutes? _____
 Sit or Stand more than 30 minutes? _____
 Sit or stand more than 1 hour? _____

Eating & Drinking

Are you able to:
 Cut up your meat? _____
 Lift a full cup or glass to your mouth? _____
 Open cartons/jars? _____

Walking

Are you able to:
 Walk outdoors on flat ground? _____
 Climb up steps? _____
 Walk for any prolonged distance? _____

Sleep

Are you able to:
 Sleep without disturbances? _____

Reaching/Grip

Are you able to:
 Reach down & pick up an object? _____
 Reach above head & retrieve an object? _____
 Turn faucets on & off? _____

Arising

Are you able to:
 Stand up from a straight chair? _____
 Get in & out of bed? _____

Activities

Are you able to:
 Run errands & shop? _____
 Get in & out of a car? _____
 Do chores such as vacuuming or yardwork? _____

Lifting

Are you able to:
 Lift without pain? _____

Signature: _____

Date: _____

HIPAA Release

I understand that some of my health information may be used and/or disclosed by Lovett Chiropractic Pain Relief Clinic to carry out treatment, payment, or health care operations, and that a complete description of such uses and disclosures has been made available to me in writing. I also understand that I can request a copy of this privacy notice entitled "Our Privacy Policies", and that disclosures of my health information for any other reason must be agreed upon by me in writing. Initial: _____

Health Insurance/Payment Information

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this Office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. Initial: _____

Informed Consent to Chiropractic Treatment

The Nature of Chiropractic Treatment: Chiropractic health care seeks to restore health through natural means without the use of medicine or surgery. Chiropractors commonly use their hands or a mechanical device in order to restore mobility and function of joints that are not moving or functioning optimally. For many patients certain therapies or exercises may also be used to maximize healing and pain relief.

Possible Risks: The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problem. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give a chiropractic adjustment, or other treatment, if he/she is aware that such care may cause problems. It is the patient's responsibility to inform the doctor of any known pathological defects, illnesses, or deformities which would not otherwise come to the attention of the doctor. The most common adverse effects are minor and temporary and include stiffness or soreness after the first few days of treatment (similar to starting a new exercise regimen or having braces put on your teeth). Other rare but potential complications include muscular strain, fractures of bone, injury to intervertebral discs, nerves or spinal cord, or stroke/cerebrovascular injury (*estimated to be less than 1 in 2 million to 5.8 million cervical manipulations*). Complications from therapies used in addition to your adjustment are rare but may cause skin irritation, burns, soreness, or other minor complications.

Risks of remaining untreated: Delay of treatment often results in further deterioration of the condition and may lead to chronic pain and disability, or spine surgery.

I have read the above explanation of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment and hereby give my full consent to treatment. Initial: _____

Patient Name (printed): _____

Date: _____

Patient Signature: _____