Lovett Chiropractic Pain Relief Clinic

REQUIRED FOR YOUR CASE HISTORY FILE

(Form CH2017)

Name: _____Date of Birth: _____ Age: ____ Gender: Male Female
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____
Email: _____ Occupation: _____
Emergency Contact: _____ Phone: _____ Relationship: _____
Insurance Carrier: _____
Marital Status (circle): Married Single Widowed Divorced Separated Number of Children: _____
Name of Spouse/Guardian: _____
Smoking Status: Current Daily ____ Current Some Days ____ Former ____ Never ____
Please list current medications with dosages (mg): _____
_____
Please list medication allergies: _____
Race: White Black Native American Asian Other Unknown Ethnicity: Hispanic Non-Hispanic
MAIN COMPLAINT TODAY: _____

Any other current symptoms? (*check all answers*)

( ) Headaches	( ) Dizziness	( ) Sleeping Problems	( ) Buzzing in Ears	( ) Fainting
( ) Neck Pain	( ) Feet Cold	( ) Nervousness	( ) Loss of Smell	( ) Face Flushed
( ) Neck Stiff	( ) Hands Cold	( ) Head Feels Heavy	( ) Loss of Taste	( ) Cold Sweats
( ) Back Pain	( ) Depression	( ) Loss of Memory	( ) Lights Bother Eyes	( ) Ears Ring
( ) Tension	( ) Fatigue	( ) Shortness of Breath	( ) Head Feels Heavy	( ) Diarrhea
( ) Irritability	( ) Fever	( ) Numb in Fingers	( ) Pins/Needles in Arms	( ) Loss of Balance
( ) Chest Pain	( ) Constipation	( ) Stomach Upset	( ) Pins/Needles in Legs/Toes	

Please list any health conditions/surgeries you have been treated for in the last year: _____
_____
Please explain any previous serious illness: _____
_____
Anyone in your family history with the following? If yes, please list relationship to you:
Heart Disease _____ Back Problems _____
Cancer _____ Disc Problems _____
Diabetes _____ Arthritis _____
Other _____

Have you ever suffered from: (*circle your answer*)

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

If yes, explain:_____

FEMALES ONLY (For X-ray Purposes): Are you possibly pregnant? Yes_____ No_____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____

Functional Rating Index

For use with **Neck and/or Back Problems** only.

In order to properly assess your condition, we must understand how much your **neck and/or back problems** have affected your ability to manage everyday activities.
For each item below, **please circle the number which most closely describes your condition right now.**

1. Pain Intensity

0	1	2	3	4
No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

2. Sleeping

0	1	2	3	4
Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep

3. Personal Care (washing, dressing, etc.)

0	1	2	3	4
No pain; no restrictions	Mild pain; no restrictions	Moderate pain; need to go slowly	Moderate pain; need some assistance	Severe pain; need 100% assistance

4. Travel (driving, etc.)

0	1	2	3	4
No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain on short trips

5. Work

0	1	2	3	4
Can do usual work plus unlimited extra work	Can do usual work; no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot work

6. Recreation

0	1	2	3	4
Can do all activities	Can do most activities	Can do some activities	Can do a few activities	Cannot do any activities

7. Frequency of pain

0	1	2	3	4
No pain	Occasional pain; 25% of the day	Intermittent pain; 50% of the day	Frequent pain; 75% of the day	Constant pain; 100% of the day

8. Lifting

0	1	2	3	4
No pain with heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight

9. Walking

0	1	2	3	4
No pain; any distance	Increased pain after 1 mile	Increased pain after 1/2 mile	Increased pain after 1/4 mile	Increased pain with all walking

10. Standing

0	1	2	3	4
No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after 1/2 hour	Increased pain with any standing

Name _____ **ID#/SS#** _____ **Plan ID** _____ **Total Score** _____

PRINTED

_____

Signature

_____

Date

PARTIAL ASSIGNMENT OF THE CAUSES OF ACTION, ASSIGNMENT OF PROCEEDS CONTRACTUAL LIEN & AUTHORIZATION

(Form CLA2017)

Purpose. The purpose of this Assignment is to improve the ability of the Office to collect my Charges directly from various Payers. Accordingly, I agree to the following and direct all Payers as follows:

Definitions. In this Assignment, the following terms shall have the following meaning: "Office" and "Clinic" shall refer to Lovett Chiropractic Pain Relief Clinic; "Payer" shall refer to, without limit, any insurance carrier, health benefit plan administrator and fiduciary, health maintenance organization, preferred and independent provider organization, attorney, at-fault party, individual, and any other entity, which may elect or be obligated to pay or disburse Proceeds to me, either now or in the future, for any reason; "Proceeds" shall include, without limit, the proceeds from any settlement, judgement, or verdict, the proceeds from any promise to pay or reimburse, and the proceeds relating to the following benefits, plans, or coverages: individual and group health benefits, Medicare, Medicaid, worker's compensation, disability, liability, uninsured and underinsured motorist, no-fault, medical payments benefits, personal injury protection, lost wages, lost services, property damage, and malpractice; "Charges" shall include, without limit, the full fees for the Office's services (including, without limit, treatment, medical equipment, supplies, supplements, narrative reports, photocopies, depositions, and testimony), and Collection Costs incurred by the Office, interest (and penalties on delinquent Charges) to the extent permitted by law, and any other charges incurred by me at the Office; "Collection Costs" shall Include, without limit, any pre- and post judgement court costs, filing fees, service of process charges, attorney fees, and any other costs of collection incurred by the office in any effort or action to collect my Charges either from me or from any Payer.

Partial Assignment of the Causes of Action, Assignment of Proceeds, and Contractual Lien. I hereby assign to the Office, Insofar as permitted by law, but only to the extent of my Charges, all of my rights, remedies, and benefits relating to any Payer, including without limit my right to receive Proceeds from any Payer now or in the future, and any and all causes of action that I might have against any Payer now or in the future, the right to prosecute such causes of action either in my name or in the Office's name, and the right to settle or otherwise resolve such causes of action as the Office sees fit. I further grant a contractual lien to the Office with respect to my Charges. I further intend for this Agreement to create a secured interest under the applicable Uniform Commercial Code and hereby direct the Office to file the form(s) normally filed with the secretary of state or other governmental agency in order to perfect such lien. Consistent with these provisions, I hereby direct any and all Payers, to pay the Proceeds directly to, immediately to, and exclusively in the name of, the Office to the extent of my Charges.

Specific Direction to Any Attorney I Retain, Such as in Accident Cases. In the event that I retain one or more attorneys to assist me in collecting any Proceeds, I hereby direct (and the Office hereby requests) each attorney to provide immediate notice to the Office regarding any Proceeds received by the attorney, to promptly pay the Office in-full out of such Proceeds, and to provide a full accounting of such Proceeds to the Office. I agree that the purpose of any Proceeds received by the attorney is to pay my Charges.

Other Disclosure Authorization. I hereby direct all Payers to release to the Office any pertinent information regarding any coverage I may have including without limit the amount of the coverage, the amount paid thus far, and the amount of any outstanding claims. I authorize and direct the Office to release any information regarding my treatment or pertinent to my case(s), including without limit a copy of my Charges and a copy of this Assignment, to all Payers in order to facilitate collection of my Charges.

Miscellaneous Provisions. Except as provided in this paragraph, this Assignment shall not be modified or revoked without the expressed, written consent of the Office, I hereby revoke, with the Office's consent, the terms of any previously signed documents, but only to the extent those terms conflict with the terms of this Assignment. I agree that each and every provision of this Assignment is reasonably necessary for the protection of the rights and interests of the Office and myself. However, should any provision of this Assignment be found to be invalid, illegal or unenforceable, or for any reason cease to be binding on any party hereto, all other portions and provisions of this Assignment shall, nevertheless, remain in full force and effect. This Assignment shall be governed under the laws of the state where the office is located, and is performable in the county where the Office is located. In any action based upon this Assignment, I hereby consent to personal jurisdiction and venue of any court in said county and waive all objections based on improper jurisdiction, venue, or forum non-conveniens as such term is defined by law. I further waive any statute of limitations which may apply in any action based upon this Assignment.

I have read, understood, and agree to the terms of this Assignment.

Patient Name (print): _____

Patient Signature: _____ Date: ____ / ____ / ____

Name of Custodial Parent or Legal Guardian, on Behalf of the Patient (please print): _____

Parent/Guardian Signature: _____ Date: ____ / ____ / ____