

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

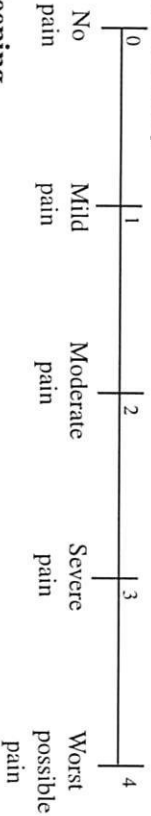
WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____

Functional Rating Index

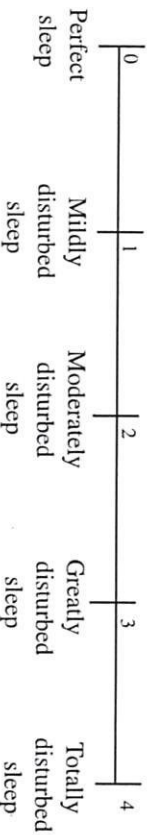
For use with Neck and/or Back Problems only.

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.

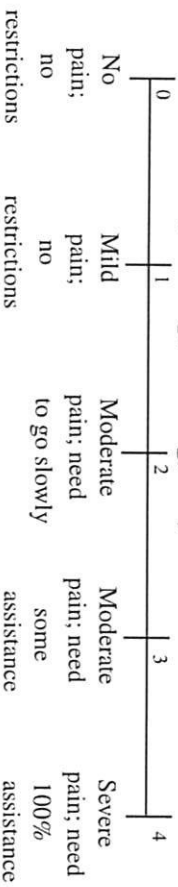
1. Pain Intensity



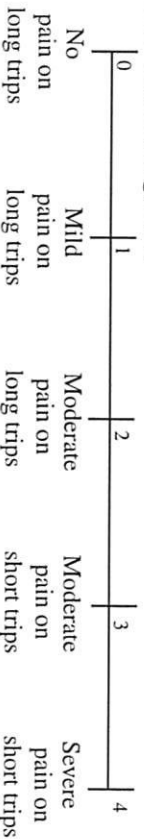
2. Sleeping



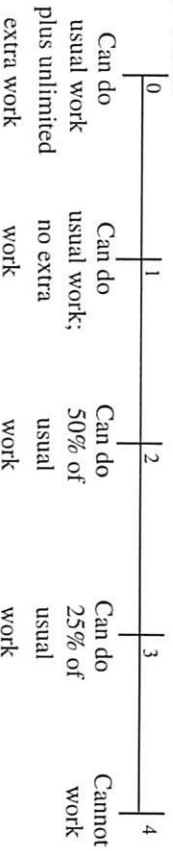
3. Personal Care (washing, dressing, etc.)



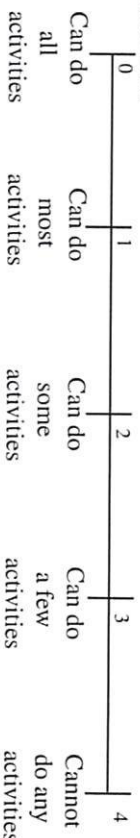
4. Travel (driving, etc.)



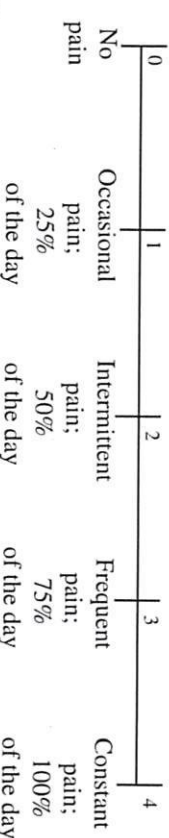
5. Work



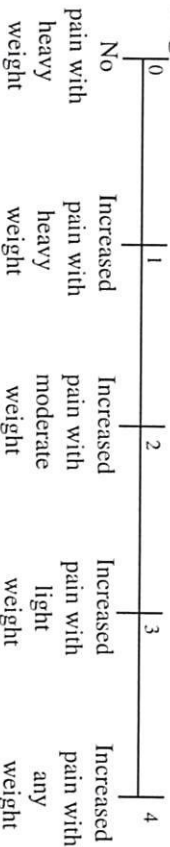
6. Recreation



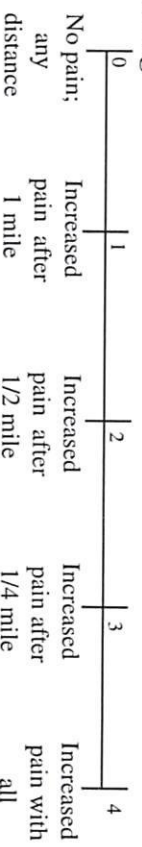
7. Frequency of pain



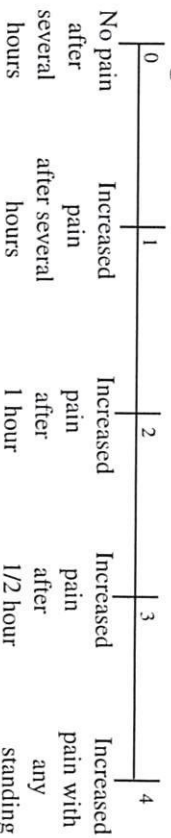
8. Lifting



9. Walking



10. Standing



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

Signature _____

Date _____