



**Lovett Family Chiropractic  
& Wellness Center  
Case History/Patient Information**

**Please provide the front desk with a photo ID & most current insurance card.**

**Name:** \_\_\_\_\_ **Nickname:** \_\_\_\_\_ Today's Date: \_\_\_\_\_  
**Address:** \_\_\_\_\_ **Apt#:** \_\_\_\_\_ **City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_  
**Social Security#:** \_\_\_\_\_ **Marital:** M S W D **Birth Date:** \_\_\_\_\_ **Age:** \_\_\_\_\_

**Occupation:** \_\_\_\_\_ **Employer:** \_\_\_\_\_

**Home #:** \_\_\_\_\_ **Cell #:** \_\_\_\_\_ **Ok to contact you via text:** YES NO

**E-Mail:** \_\_\_\_\_ **Ok to E-mail LFC Newsletter to you:** YES NO

\*Your information (including e-mail address & phone number will never be shared with anyone)

**Spouse:** \_\_\_\_\_ **Phone#:** \_\_\_\_\_

**How many children?** \_\_\_\_\_ **Names and Ages of Children:** \_\_\_\_\_

**Emergency Contact:** \_\_\_\_\_ **Phone #:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_

**Who referred you to our office?** \_\_\_\_\_

**Family Medical Doctor:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

May we update your medical doctor regarding your care at this office? YES NO

Who is ultimately responsible for this account? \_\_\_\_\_

**PAST MEDICAL HISTORY**

Have you ever been diagnosed as having or have suffered from? (Place a check by those that apply to you)

<input type="checkbox"/> Broken or Fractured Bones	<input type="checkbox"/> Osteoarthritis	<input type="checkbox"/> Eating Disorder	<input type="checkbox"/> Tumors
<input type="checkbox"/> Circulatory Problems	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Skin Disorders
<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/> Pacemaker/IED	<input type="checkbox"/> Drug Addiction	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Seizures/Convulsions	<input type="checkbox"/> Strokes	<input type="checkbox"/> HIV Positive	<input type="checkbox"/> Vascular problems
<input type="checkbox"/> A Congenital Disease	<input type="checkbox"/> Cancer	<input type="checkbox"/> Gall Bladder	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Excessive Bleeding	<input type="checkbox"/> Ruptures	<input type="checkbox"/> Depression	<input type="checkbox"/> Coughing Blood

Do you have a **history of stroke, hypertension or high blood pressure?** YES NO

Have you had any major illnesses, injuries, falls, auto accidents or surgeries? Women, please include information about childbirth (include dates): \_\_\_\_\_

Have you been treated for any health condition by a physician in the last year? YES NO

If yes, describe: \_\_\_\_\_

What **medications or drugs** are you taking? Date started/stopped and dosage. Prescribed by: Dr or Self

\_\_\_\_\_

What **Vitamins or Supplements** are you taking? Date started/stopped and dosage. Prescribed by: Dr or Self

\_\_\_\_\_

Do you have any allergies of any kind? YES NO If yes, describe: \_\_\_\_\_

\_\_\_\_\_

Please list any other health problems you have, no matter how insignificant they may be: \_\_\_\_\_

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**SOCIAL HISTORY**

Do you drink alcoholic beverages? YES NO If yes, how much per week? \_\_\_\_\_

Do you use any tobacco products? YES NO Do you smoke? YES NO If yes, packs per day: \_\_\_\_\_

Do you consume caffeine? YES NO If so, how much per day: \_\_\_\_\_

Do you exercise? YES NO If yes, what is the frequency and type of exercise? \_\_\_\_\_

**FAMILY HISTORY**

**Father:** Living \_\_\_ Deceased \_\_\_ Current age if still living: \_\_\_\_\_ Cause of death and age at death if deceased: \_\_\_\_\_

**Mother:** Living \_\_\_ Deceased \_\_\_ Current age if still living: \_\_\_\_\_ Cause of death and age at death if deceased: \_\_\_\_\_

Do you have any family members who suffer from the same condition you do? If so, please list: \_\_\_\_\_

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**FAMILY DISEASES** (check if applicable and indicate whether family member is Father, Mother, Sister, Brother):

\_\_\_\_ Tuberculosis      \_\_\_\_ Cancer      \_\_\_\_ Mental Illness      \_\_\_\_ Lung Disease  
\_\_\_\_ Diabetes      \_\_\_\_ Asthma      \_\_\_\_ Heart Disease      \_\_\_\_ Kidney Disease  
\_\_\_\_ Stroke      \_\_\_\_ Arthritis      \_\_\_\_ Liver Disease      \_\_\_\_ Other \_\_\_\_\_

**INSURANCE COVERAGE** (Please check any and all insurance coverage that may be applicable in this case)

\_\_\_\_ Major Medical      \_\_\_\_ Medicare      \_\_\_\_ Auto Accident      \_\_\_\_ Worker's Compensation  
\_\_\_\_ Medical Savings Account & Flex Plans      \_\_\_\_ Other \_\_\_\_\_

Name of Primary Insurance Company: \_\_\_\_\_

Name of Secondary Insurance Company (if any): \_\_\_\_\_

**AUTHORIZATION AND RELEASE:** I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

**The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office.**

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Guardian's Signature Authorizing Care: \_\_\_\_\_ Date: \_\_\_\_\_

# Summary of Chief Complaint

1. What is your major symptom? \_\_\_\_\_
2. Have you ever had this symptom before? \_\_\_\_\_
3. What does this prevent you from doing or enjoying? \_\_\_\_\_
4. If this is a recurrence, when was the first time you noticed this problem? \_\_\_\_\_  
How did it originally occur? \_\_\_\_\_  
Has it become worse recently? YES NO  
If yes, gradual or sudden, when and how? \_\_\_\_\_
5. How frequent is the condition? \_\_\_ Constant \_\_\_ Daily \_\_\_ Intermittent \_\_\_ Night Only  
How long does it last? \_\_\_ All Day \_\_\_ Few Hours \_\_\_ Minutes
6. Describe the pain: \_\_\_ Sharp \_\_\_ Dull \_\_\_ Numbness \_\_\_ Tingling \_\_\_ Aching  
\_\_\_ Burning \_\_\_ Stabbing \_\_\_ Other \_\_\_\_\_
7. Is there anything you can do to relieve the problem? YES NO If **yes**, describe: \_\_\_\_\_  
\_\_\_\_\_ If **no**, what have you tried to do that has not helped? \_\_\_\_\_
8. What makes the problem worse? \_\_\_ Standing \_\_\_ Sitting \_\_\_ Lying \_\_\_ Bending  
\_\_\_ Lifting \_\_\_ Twisting \_\_\_ Other \_\_\_\_\_
9. List any major accidents you have had other than those that might be mentioned above:  
\_\_\_\_\_
10. WOMEN ONLY: Are you pregnant or is there any possibility you may be pregnant?  
YES NO UNCERTAIN
11. Other Concerns \_\_\_\_\_
12. How does this problem effect your day to day life? (ie: difficulty sleeping, difficulty working, difficulty doing things at home etc...) \_\_\_\_\_

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Rate your pain from 0 – 10 (0 being no pain and 10 being the worst pain imaginable)

Please place an "X" on the line below to indicate level of problem.

\_\_\_\_\_

1      2      3      4      5      6      7      8      9      10

Patient/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Doctor's Signature \_\_\_\_\_ Date \_\_\_\_\_

# Pain Drawing

TELL US WHERE YOU HURT.

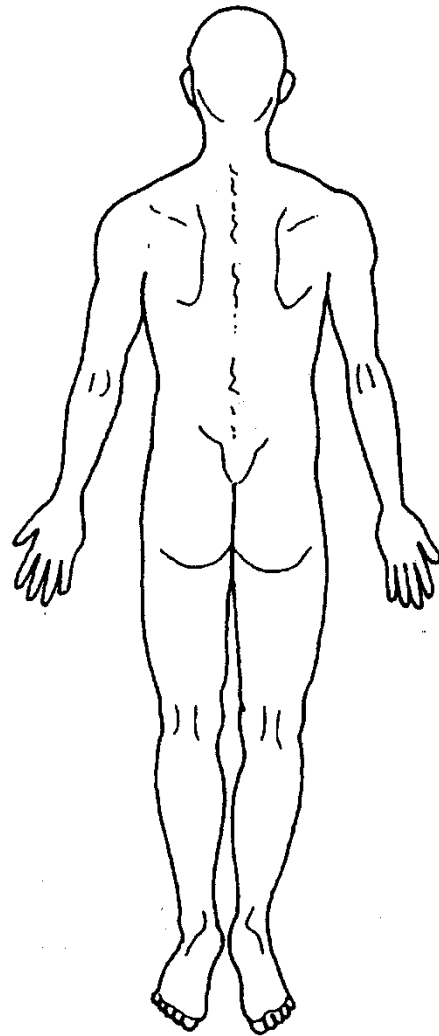
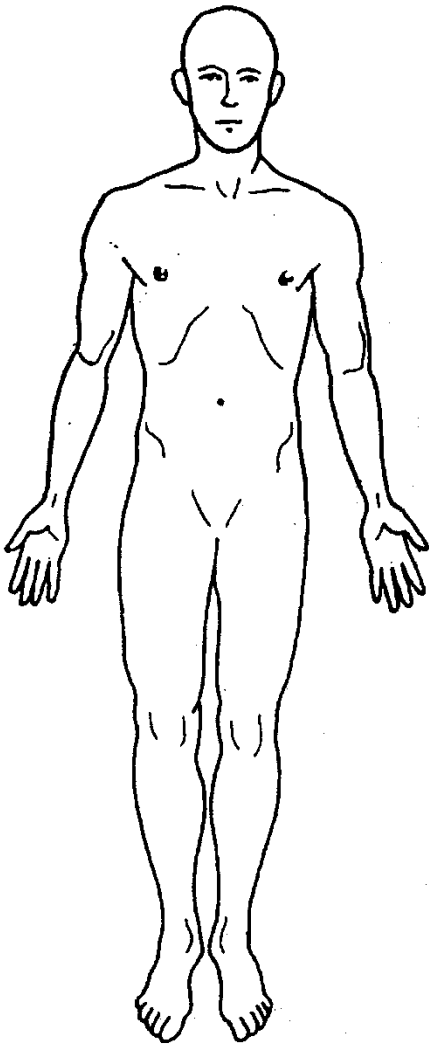
*Please read carefully:*

*Mark the areas on your body where you feel your pain. Include all affected areas. Mark areas of radiation. If your pain radiates, draw an arrow from where it starts to where it stops. Please extend the arrow as far as the pain travels. Use the appropriate symbol(s) listed below.*

Ache = A  
Burning = B

Numbness = N  
Stabbing = S

Pins & Needles = P  
Throbbing = T



## **Informed Consent For Chiropractic Care and Therapies**

Chiropractic care, like ALL forms of health care, while offering considerable benefit 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 and therapies include stiffness, soreness, discomfort, skin irritation, sprain/strain injuries, irritation of a disc condition, and very rarely, fractures.

Prior to receiving chiropractic care this Chiropractic office, a thorough health history and physical examination will be completed. These procedures are performed to assess your specific condition, 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 that chiropractic adjustments involve the doctor placing his or her hands on me and delivering a very specific, quick thrust or impulse to the involved area(s). Alternatively, the doctor may use an instrument in place of his or her hands. I understand and accept that there are risks and benefits associated with chiropractic care and give my consent to the examinations that the doctor deems necessary, and to the chiropractic care including spinal adjustments and other therapies, as reported following my assessment.

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Printed Name

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Signature of Patient

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Date

## **Informed Consent to X-Rays (Pregnancy Release)**

In order for Lovett Family Chiropractic to correctly evaluate, diagnose and treat my condition, x-rays may be needed. X-Rays expose the patient to radiation, similar to the amount of radiation on a Trans-Atlantic flight. Repeated exposure to radiation has been correlated to increase cancer risk. I grant LFC permission to perform x-rays, if needed, and assume all risks and responsibilities from an x-ray procedure.

The radiation in x-rays may be harmful to an unborn child/developing fetus. I understand that there are risks involved in exposing an unborn child to radiation and assume all responsibility for receiving an x-ray procedure. By my signature below, I certify that I am not pregnant at the time of this x-ray procedure.

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Printed Name

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Signature of Patient

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Date

## **Pacemaker Release**

I hereby certify that I do not have a Pacemaker or Defibrillator of any kind in or on my body. I understand that if I do have one of these devices in or on my body, I will let the doctor know and my treatment may be slightly altered as a result.

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Printed Name

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Signature of Patient

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Date

# **Patient Health Information Consent Form**

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is obligated to agree to those restrictions only to the extent they coincide with state and federal law.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. Our office may contact you periodically regarding appointments, treatments, products, services, or charitable work performed by our office. You may choose to opt-out of any marketing or fundraising communications at any time.
6. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
7. Patients have the right to file a formal complaint with our privacy official and the Secretary of HHS about any possible violations of these policies and procedures without retaliation by this office.
8. Our office reserves the right to make changes to this notice and to make the new notice provisions effective for all protected health information that it maintains. You will be provided with a new notice at your next visit following any change.
9. This notice is effective on the date stated below.
10. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

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Printed Patient Name

Patient/Guardian Signature

Date

For further information regarding this notice, please contact our office at (720) 747-1500.