



**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:** _____ **Office #:** _____

Home #: _____ **Cell #:** _____ **Best # to reach you:** HOME CELL OFFICE

Ok to Send Text Messages?: YES NO **E-Mail:** _____

Spouse: _____ **Phone#:** _____ **Occupation:** _____ **Employer:** _____

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: _____

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? _____

What are your hobbies? _____

What percentage of time during the day (at home or at your job away from home) do you spend:

Lifting _____ Sitting _____ Standing _____ Walking _____

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: _____

Check if applicable to you: _____ As an adopted child, little is known of birth parents or family.

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

FAMILY DISEASES (check if applicable and indicate whether family member is **F**ather, **M**other, **S**ister, **B**rother):

_____ 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. Are there any other conditions or symptoms that may be related to your major symptom?
YES NO If yes, describe: _____
Are there other unrelated health problems? YES NO
If yes, describe: _____
7. Describe the pain: ___ Sharp ___ Dull ___ Numbness ___ Tingling ___ Aching
___ Burning ___ Stabbing ___ Other _____
8. 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? _____
9. What makes the problem worse? ___ Standing ___ Sitting ___ Lying ___ Bending
___ Lifting ___ Twisting ___ Other _____
10. List any major accidents you have had other than those that might be mentioned above:

11. WOMEN ONLY: Are you pregnant or is there any possibility you may be pregnant?
YES NO UNCERTAIN
12. Other Concerns _____
13. 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.

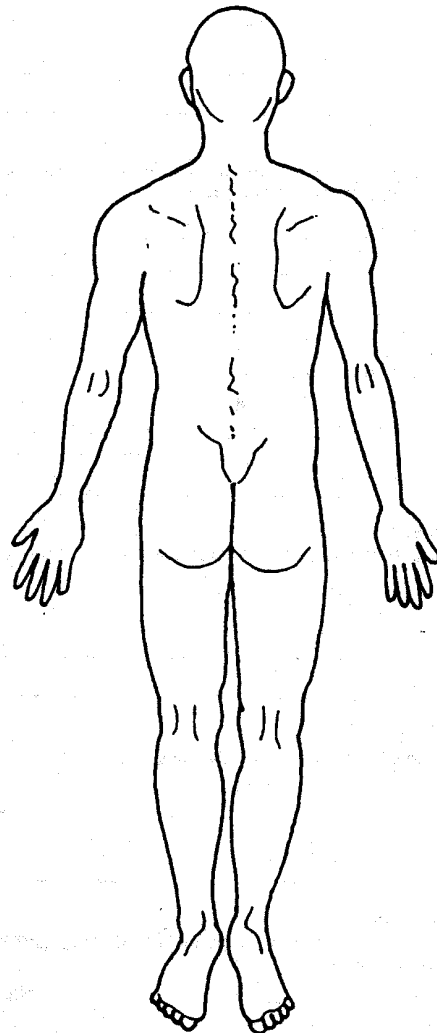
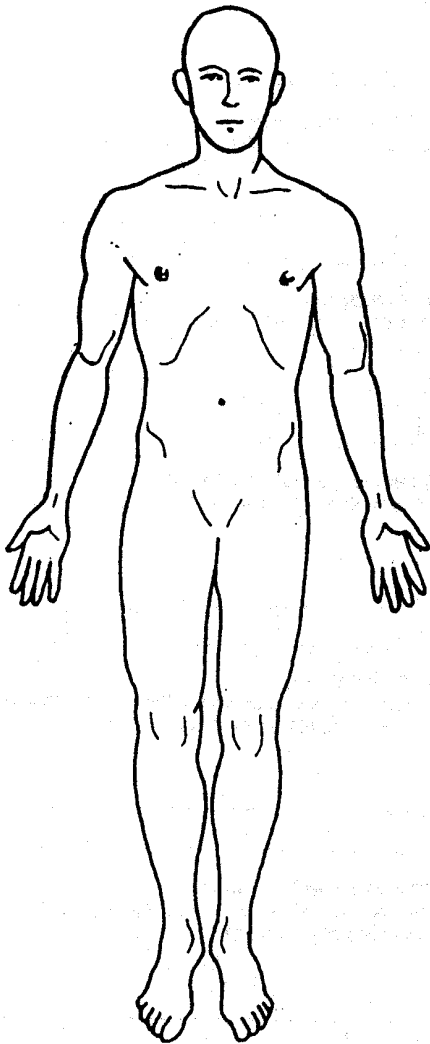
Please read carefully:

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 to Chiropractic Treatment

I, the undersigned, a patient in this office, hereby authorize Lovett Family Chiropractic & Wellness Center/ Dr. Patrick Lovett (and whoever he may designate as his alternate) to administer such treatment as is necessary, and to perform the needed therapy and procedures that are considered therapeutically necessary on the basis of finding during the course of my treatment.

I hereby certify that I have read and fully understand this Informed Consent for Chiropractic Treatment. I further certify that I comprehend the reasons why treatment is considered necessary, its advantages and possible complications, if any, as well as possible alternative modes of treatment have been explained to me by Dr. Lovett (or his alternate). I also certify that no guarantee or assurance has been made to me as to the results that may be obtained.

Printed Name of Patient

Signature of Patient

Date

Informed Consent to Radiographic Studies

By my signature below, I hereby state that to the best of my knowledge I am NOT pregnant at this time. I consent to the performance of suggested radiographic studies and am acknowledging a willingness for these tests to be performed if the doctor finds them to be necessary. . . *I hereby certify that I have read and fully understand this Informed Consent to Radiographic Studies.*

Printed Name of Patient

Signature of Patient

Date

Informed Consent to Cold Laser Therapy

I, the undersigned, a patient in this office, hereby authorize Lovett Family Chiropractic & Wellness Center/ Dr. Patrick Lovett (and whoever he may designate as his alternate) to administer cold laser therapy as is necessary, on the basis of finding during the course of my treatment.

I hereby certify that I have read and fully understand this Informed Consent to Cold Laser Therapy. I further certify that I comprehend the reasons why treatment is considered necessary. I also certify that no guarantee or assurance has been made to me as to the results that may be obtained.

By my signature below, I hereby state that to the best of my knowledge I am NOT pregnant at this time. I consent to the performance of cold laser therapy. I realize that this procedure is completely elective. I further warrant that I do not have a pacemaker or any form of cancer and have not had any form of cancer in the last five years.

Printed Name of Patient

Signature of Patient

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.

_____ (pt initials) I give permission to Lovett Family Chiropractic & Wellness Center to use my address, telephone number & clinical records to contact me with appointment reminders, missed appointment notifications, holiday related cards, information about treatment alternatives, and other health related information.

_____ (pt initials) If Lovett Family Chiropractic & Wellness Center contact me by telephone, I give them permission to leave a phone message on my answering machine/voice mail.

_____ (pt initials) I give Lovett Family Chiropractic & Wellness Center permission to treat me in an open room where other parties may also be receiving treatment. I am aware that other non-staff persons in the office may overhear some of my protected health information during the course of care. I am aware that should I need to speak with Dr Lovett, that a private room is available.

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 not obligated to agree to those restrictions.
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. 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.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. 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.

Printed Patient Name

Patient/Guardian Signature

Date