Lovett Family Chiropractic
12201 E Arapahoe Rd, #B-10
Centennial, CO 80112

ABOUT THE PATIENT

Name _____ Preferred Name _____ Birthdate _____

Address _____ City _____ State _____ Zip _____

Primary Phone _____ (cell / home / work) Alternate Phone _____ (cell / home / work) Gender ❑ M ❑ F

e-Mail Address _____ Preferred Method of Contact ❑ Email ❑ Text ❑ Phone (cell / home / work)

Referred By _____ Have you been to a chiropractor before? ❑ No ❑ Yes

Significant Other's Name _____ Kid's Names and Ages _____

Your Employer _____ Type of Work _____

Emergency Contact _____ Relationship _____ Phone Number _____

Will you be working with Insurance ❑ No (self pay) ❑ Yes Is today's visit the result of an accident? ❑ No ❑ Auto ❑ Work

Primary _____ ID #_____ Secondary _____ ID #_____

Name of Primary Care Physician _____

- I authorize Lovett Family Chiropractic to request records from other providers as may be necessary.
- Person responsible for this account if other than the patient?_____
- I understand that after any initial promotional services all care is rendered at usual and customary fees.

_____ _____

Patient / Parent Signature (This represents a long term authorization for all occasions of service) Date

REASON FOR SEEKING CARE

PRESENT COMPLAINTS

1. _____ How long has this been an issue? _____

Is it: ❑ Dull ❑ Sharp ❑ Ache ❑ Numb / Tingle ❑ Stabbing ❑ Constant ❑ Occasional ❑ Staying the same ❑ Getting worse ❑ Mild ❑ Moderate ❑ Severe ❑ Worse in the morning ❑ Worse in evening ❑ Pain radiates to_____

2. _____ How long has this been an issue? _____

Is it: ❑ Dull ❑ Sharp ❑ Ache ❑ Numb / Tingle ❑ Stabbing ❑ Constant ❑ Occasional ❑ Staying the same ❑ Getting worse ❑ Mild ❑ Moderate ❑ Severe ❑ Worse in the morning ❑ Worse in evening ❑ Pain radiates to_____

3. _____ How long has this been an issue? _____

Is it: ❑ Dull ❑ Sharp ❑ Ache ❑ Numb / Tingle ❑ Stabbing ❑ Constant ❑ Occasional ❑ Staying the same ❑ Getting worse ❑ Mild ❑ Moderate ❑ Severe ❑ Worse in the morning ❑ Worse in evening ❑ Pain radiates to_____

4. _____ How long has this been an issue? _____

Is it: ❑ Dull ❑ Sharp ❑ Ache ❑ Numb / Tingle ❑ Stabbing ❑ Constant ❑ Occasional ❑ Staying the same ❑ Getting worse ❑ Mild ❑ Moderate ❑ Severe ❑ Worse in the morning ❑ Worse in evening ❑ Pain radiates to_____

5. Does your condition affect: ❑ Sleep ❑ Work ❑ Daily Routine ❑ Sitting ❑ Driving

6. What makes it better?_____

7. What makes it worse? _____

8. What Doctor's have you seen for this?_____

_____

9. Type of treatment:_____

10. Results: _____

NOTES: _____

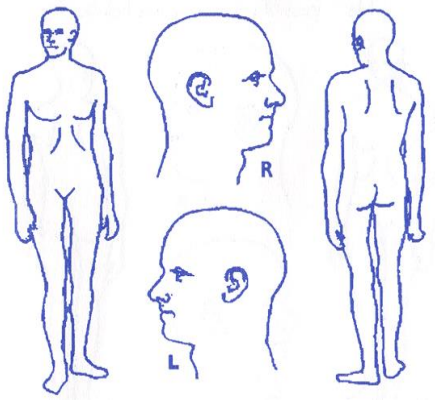
_____

_____

Are you pregnant?

❑ Yes ❑ No

Please mark all areas of concern.



GENERAL HEALTH HISTORY

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Patient Name_____ *Mark the conditions that apply to you.*

Past	Present		Past	Present	
❑	❑	Headaches	❑	❑	Urinary Problems
❑	❑	Migraines	❑	❑	Easy Bruising
❑	❑	Shortness of Breath	❑	❑	Tobacco Use
❑	❑	Allergies / Asthma	❑	❑	Dental Problems
❑	❑	Medication Side Effects	❑	❑	Fibromyalgia
❑	❑	Diabetes	❑	❑	Blood Thinner use
❑	❑	Hands or Feet cold	❑	❑	HIV Positive
❑	❑	Muscle aches	❑	❑	Cancer
❑	❑	Trouble Walking	❑	❑	Depression
❑	❑	Leg / Foot Numbness	❑	❑	Alcohol Use
❑	❑	Fainting	❑	❑	___High or ___Low Blood Pressure
❑	❑	Gall Bladder Trouble	❑	❑	Stroke History
❑	❑	Ringing in Ears	❑	❑	High Cholesterol
❑	❑	Ear Problems	❑	❑	TMJ
❑	❑	Sleeping Problems	❑	❑	Digestive Problems
❑	❑	Vision Problems	❑	❑	Pain all Over
❑	❑	Thyroid Problems	❑	❑	Tension / Irritability
❑	❑	Liver Disease	❑	❑	Chest Pains
❑	❑	Kidney Problems	❑	❑	Heart Pacemaker
❑	❑	Light Bothers Eyes	❑	❑	Heart Problems
❑	❑	Other _____			

1. **List any medications you are taking:**_____

_____

2. **Please list all doctors you are currently seeing:** _____

_____

3. **Has any Doctor or other professional advised you to "Go to a Chiropractor ":** ❑ No ❑ Yes, Name_____

_____

_____

PAST HISTORY

4. **List any past auto collisions:**_____ **Was any care received?**_____
5. **List any past work injuries:** _____ **Was any care received?**_____
6. **List any past sport, recreational, or home injuries**_____
7. **Please describe any past conditions and treatment received:** _____

_____

8. **Please list any past hospitalizations and surgeries:** _____

_____

FAMILY HISTORY

Father's side: □ Heart Disease □ Cancer □ Diabetes □ Heavy Medication use □ Arthritis □ Other_____

Mother's side: □ Heart Disease □ Cancer □ Diabetes □ Heavy Medication use □ Arthritis □ Other_____

Is there any other family history you want us to know?_____

Functional Rating Index

Patient Name: _____ **D.O.B.:** _____

For each item below please circle the number which best describes your condition right now.

1. Pain Intensity

0- No pain	1- Mild Pain	2-Moderate Pain	3- Severe Pain	4- Worst Possible Pain

2. Sleeping

0- Perfect Sleep	1-Mildly Disturbed	2- Moderately Disturbed	3- Greatly Disturbed	4- Totally Disturbed

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

0- No pain No Restrictions	1- Mild Pain No Restrictions	2-Moderate Pain Go Slowly	3- Moderate Pain Some Assistance	4- Severe Pain 100% Assistance

4. Traveling (flying, driving, etc.)

0- No pain on Long Trips	1- Mild Pain on Long Trips	2- Moderate Pain on Long Trips on	3- Moderate Pain Short Trips	4- Severe Pain on Short Trips

5. Work (job, chores, etc.)

0- Usual Work + Extra Work	1- Usual Work No Extra	2- 50% of Usual Work Only	3- 25% of Usual Work	4- Cannot Work at all

6. Recreation (exercising, playing, T.V., etc.)

0- Can do All Activities	1- Can do Most Activities	2- Can do Some Activities	3- Can do Few Activities	4- Cannot do Any Activities

7. Frequency of Pain

0- No Pain	1- Occasional{25%)	2- Intermittent{50%)	3- Frequent{75%)	4- Constant{100%)

8. Lifting

0- No Pain with Heavy Weight	1- Increased Pain with Heavy Weight	2- Increased Pain with Moderate Weight	3- Increased Pain with Light Weight	4- Increased Pain with Any Weight

9. Walking

0- No Pain with Any Distance	1- Increased Pain after 1 Mile	2- Increased Pain After ½ of a Mile	3- Increased Pain After ¼ of a Mile	4- Increased Pain After Any Distance

10. Standing

0- No Pain with Any Time	1- Increased Pain After Several Hours	2- Increased Pain After 1 Hour	3- Increased Pain After Half an Hour	4- Increased Pain After Any Time

Patient Signature: _____ Date: _____Total

_____ (/4 x 10) = Functional Rating Score_____ %

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INFORMED CONSENT FOR CHIROPRACTIC SERVICES

I have been informed of the following:

That the process of delivering a "Chiropractic Adjustment (manipulation)" may be performed manually or with an instrument to the vertebra(e) of the spine and/or associated structures (legs, arms etc.), often resulting in an audible pop or click sound; As an addition to the Chiropractic Adjustment "Supportive Therapies" may be applied by the chiropractor or by staff under their direction or supervision incorporating the use of light, sound, vibration, electricity, traction, motion, bracing, nutritional advice, heat, or cold;

I have been informed on occasion some temporary soreness and/or stiffness may occur; less frequently aggravation of presenting symptoms or initiation of new symptoms; rarely bruising, swelling, even more rare separation/fracture; and extremely rare, nerve or vascular injury may occur in conjunction with the process of a Chiropractic Adjustment. The listed possible consequences and possible complications have been explained to me by the chiropractor;

I acknowledge that the chiropractor has made no guarantee of a positive outcome from treatment; I have been afforded ample opportunity for questions and answers; and the condition, possible benefits, risks of the treatment procedures, options, and financial obligations have been explained to me by the chiropractor.

Therefore, by signing below:

I consent to the performance of the diagnostic and therapeutic procedures performed by the doctor and or staff under the direction and supervision of the office chiropractor(s) involved in my case;

I consent to the performance of other diagnostic and therapeutic procedures in the future that may be deemed reasonable and necessary by the doctor and or staff under the direction and supervision of the office chiropractor(s) involved in my case;

Patient Signature: _____ Date: _____

Guardian Consent to Treat a Minor:

I hereby authorize Dr. Patrick Lovett and whomever he may designate as assistants to administer examinations and chiropractic care as deemed necessary to:

_____ _____
Minor's Printed Name Printed Name of Parent or Guardian

_____ _____
Signature of Parent or Guardian Date

PRIVACY NOTICE ACKNOWLEDGEMENT

We are very concerned with protecting your privacy, especially in matters that concern your personal health information. In accordance with the *Health Insurance Portability and Accountability Act* of 1996 (HIPAA), we are required to supply you with a copy of our privacy policies and procedures. We encourage you to read this document carefully, for it outlines the use and limitations of the disclosure of your health information and your rights as a patient. If you ever have any questions or concerns regarding the use or dissemination of your personal health information, we would be happy to address them.
I acknowledge that I have been offered a copy of the *Notice of Privacy Practices for Protected Health Information*.

_____ _____ _____
Patient Signature Signature of Parent or Guardian Date

_____ _____ _____
Personal Representative Printed Personal Rep. Signature Relationship to Patient

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AUTHORIZATIONS

Before this office begins any health care operations we require you to read and sign this form stating that you understand the below item. If you refuse to sign this form the doctor reserves the right to refuse care.

- ❑ **AUTHORIZATION:** By signing below you authorized this office/provider to complete a consultation and examination on the above.
- ❑ **AUTHORIZATION FOR X-RAY WITH RELEASE:** By signing below you have declared, to the best of your knowledge, that there is no chance you are pregnant at this time. By signing below you have declared that you have no known limitations that would be contraindicated for an x-ray evaluation. By signing below you consent to the taking of x-rays if there is a determined need.
- ❑ **ACKNOWLEDGMENT OF ASSIGNMENT OF BENEFITS:** By signing below you have acknowledged that you are fully responsible for all services rendered. By signing below you furthered acknowledge understanding that your health and accident insurance information policies are an arraignment between you and your carrier, and that you may be required to pay some or all of the fees charged to your account. By signing below you hereby assign benefits to paid directly to this office/provider by your third-party payer, e.g. insurance company, attorneys, etc. By signing below you agree that this is a non-rescindable agreement and failure to fulfill this obligation will be considered a breach of contract between you and this office.
- ❑ **CMS-1500 HEALTH INSURANCE CLAIM FORM**: By signing below you acknowledge and agree that the CMS-1500 Health Insurance Claim Form Box 12 and Box 13 will state "Signature on File". Box 12 Reads as follows: "PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below." Box 13 Reads as follows: "INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below."
- ❑ **ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES:** We are very concerned with protecting your personnel health information. There may be times our office may need to contact you regarding office matters. By signing below you have authorized this office to contact you for office related matters in the following manner: phone-work-home or mobile, e-mail and regular mail. Messages may be left on an answering device/voicemail, or with the person answering your phone (home-work-mobile). Also in accordance with the Health Insurance Portability and Accountability act of 1996 (HIPAA), updated September 23, 2013, this office is obliges to supply you with a copy of the office privacy policies and procedures upon request. This document outlines the use and limitations of the disclosure of your personal health information and your rights as a patient. By signing below you have acknowledged that you have been offered a copy of this document.
- ❑ **ACKNOWLEDGEMENT OF TREATMENT PLAN:** By signing below I acknowledge that, if accepted for care, I may be presented with a chiropractic treatment plan resulting in one or more of the following services: chiropractic adjustments, examinations, and supportive therapies and procedures.
- ❑ **PHOTO/NAME RELEASE:** I grant to Lovett Family Chiropractic, its representatives and employees the right to use photographs of me. I authorize Lovett Family Chiropractic, its assigns and transferees to copyright, use and publish the same in print and/or electronically. I agree that Lovett Family Chiropractic may use such photographs of me with or without my name and for any lawful purpose, including for example such purposes as publicity, illustration, advertising, and Web content.
- ❑ **ACKNOWLEDGEMENT:** By signing below you have acknowledge that you understand and agree with the policies and procedures outlined in this TERMS of ACCEPTANCE form. By signing below you acknowledge and certify that all the information given to the office/provider in the INTAKE forms are a true and accurate to the best of you knowledge.

_____ _____

Printed Patient Name Date

_____ _____

Patient Signature Guardian Signature