Patient Information

Name:		
Address:		
City:	_ State:	Zip Code:
Phone:		· · · · · · · · · · · · · · · · · · ·
Date of birth://	Age:	Gender:
Email Address:		
Emergency Contact:	,	
Phone number:		Relationship:
Employed by:		
Do you have a HSA or FSA?		
Are you Medicare Eligible?		

Patient History

Type of Pain? Sharp Dull Throbbing Tingling Shooting Stabbing Burning Radiating Aching Numbness Is it constant or does it come and go? Please indicate the location of the pain on the figures: Notes History Headaches Upper Back Pain/Stiffness Cancer AIDS/HIV Headaches Back/Spine Condition Tumors Hepatitis Neck Pain/Stiffness Herniated Disc Joint Replacement Tuberculosis Hip Pain/Stiffness Stroke Fused/Fixated Joints Hernia Shoulder Pain/Stiffness Pacemaker Osteopenia	Name	C	Occupation			
What, if anything, makes it better? What, if anything, makes it worse? Rate the severity of your pain on a scale of 1 to 10 1 (least) - 10 (worst) Type of Pain?	Have you had chiropractic	care before? Yes No W	/hen/Where?			
What, if anything, makes it worse? Rate the severity of your pain on a scale of 1 to 10 1 (least) - 10 (worst) Type of Pain? Sharp Dull Throbbing Radiating Aching Numbness Is it constant or does it come and go? Please indicate the location of the pain on the figures: Notes HISTORY Headaches Back/Spine Condition Neck Pain/Stiffness Herniated Disc Shoulder Pain/Stiffness Herniated Disc Shoulder Pain/Stiffness Seizure Disorders West Pain/Stiffness Osteopenia Osteopenia Osteoporosis Surgeries? If yes, please explain Hospitalizations Current Medical Conditions Current Medical Conditions	Reason for today's visit	Wher	did this begin?			
Rate the severity of your pain on a scale of 1 to 10 1 (least) - 10 (worst) 1 2 3 4 5 6 7 8 9 10 Type of Pain? Sharp Dull Throbbing Burning Tingling Shooting Numbness Is it constant or does it come and go? Please indicate the location of the pain on the figures: Notes	What, if anything, makes	it better?	©	\bigcirc		
Type of Pain? Sharp Dull Throbbing Burning Shooting Stabbing Burning Numbness Is it constant or does it come and go? Please indicate the location of the pain on the figures: Notes HISTORY Headaches Upper Back Pain/Stiffness Cancer AIDS/HIV Hepatitis Back/Spine Condition Tumors Hepatitis Tuberculosis Herniated Disc Joint Replacement Tuberculosis Shoulder Pain/Stiffness Pacemaker Osteopenia Low Back Pain/Stiffness Seizure Disorders Osteoporosis Other Broken bones? If yes, please explain Hospitalizations Current Medical Conditions Current Medical Conditions	What, if anything, makes	it worse?		α		
Type of Pain?	Rate the severity of your pain on a scale of 1 to 10					
Tingling Shooting Stabbing Burning Radiating Aching Numbness	1 (least) - 10 (worst)	1 (least) - 10 (worst) 1 2 3 4 5 6 7 8 9 10				
Radiating Aching Numbness Is it constant or does it come and go? Please indicate the location of the pain on the figures: Notes HISTORY Headaches Upper Back Pain/Stiffness Cancer Hepatitis Neck Pain/Stiffness Herniated Disc Joint Replacement Tuberculosis Hip Pain/Stiffness Pacemaker Osteopenia Low Back Pain/Stiffness Seizure Disorders Osteopenosis Other Broken bones? If yes, please explain Hospitalizations Current Medical Conditions Current Medical Conditions	Type of Pain? Sharp Dull Throbbing					
Is it constant or does it come and go? Please indicate the location of the pain on the figures: Notes HISTORY Headaches Back/Spine Condition Herniared Disc Herniated Disc Herniated Disc Herniated Joint Replacement Hepatitis Shoulder Pain/Stiffness Pacemaker Osteopenia Low Back Pain/Stiffness Seizure Disorders Osteoporosis Other Broken bones? If yes, please explain Hospitalizations Current Medical Conditions	Tingling Shooti	ng Stabbing Burni	ng ()(()			
Please indicate the location of the pain on the figures: Notes	Radiating Aching	Numbness	() (() (
HISTORY Headaches	Is it constant or does it co	ome and go?		\(\) \(\)		
HISTORY Headaches	Please indicate the location	on of the pain on the figures	Front	Back		
☐ Headaches ☐ Upper Back Pain/Stiffness ☐ Cancer ☐ AIDS/HIV ☐ Migraines ☐ Back/Spine Condition ☐ Tumors ☐ Hepatitis ☐ Neck Pain/Stiffness ☐ Herniated Disc ☐ Joint Replacement ☐ Tuberculosis ☐ Hip Pain/Stiffness ☐ Stroke ☐ Fused/Fixated Joints ☐ Hernia ☐ Shoulder Pain/Stiffness ☐ Pacemaker ☐ Osteopenia ☐ Low Back Pain/Stiffness ☐ Seizure Disorders ☐ Osteoporosis ☐ Other ☐ Osteoporosis ☐ Broken bones? If yes, please explain ☐ Osteoporosis ☐ Hospitalizations ☐ Osteoporosis ☐ Current Medical Conditions ☐ Osteoporosis	Notes					
Migraines Back/Spine Condition Tumors Hepatitis Neck Pain/Stiffness Herniated Disc Joint Replacement Tuberculosis Hip Pain/Stiffness Stroke Fused/Fixated Joints Hernia Shoulder Pain/Stiffness Pacemaker Osteopenia Low Back Pain/Stiffness Seizure Disorders Osteoporosis Other Broken bones? If yes, please explain Surgeries? If yes, please explain Hospitalizations Current Medical Conditions	HISTORY					
Neck Pain/Stiffness	Headaches					
Hip Pain/Stiffness Stroke Fused/Fixated Joints Hernia Shoulder Pain/Stiffness Pacemaker Osteopenia Low Back Pain/Stiffness Seizure Disorders Osteoporosis Other Broken bones? If yes, please explain Surgeries? If yes, please explain Hospitalizations Current Medical Conditions	- -	- •				
Shoulder Pain/Stiffness Pacemaker Osteopenia Low Back Pain/Stiffness Seizure Disorders Osteoporosis Other Broken bones? If yes, please explain Surgeries? If yes, please explain Hospitalizations Current Medical Conditions			-			
Low Back Pain/Stiffness						
Broken bones? If yes, please explain	Low Back Pain/Stiffness		-			
Surgeries? If yes, please explain Hospitalizations Current Medical Conditions	☐ Other					
Hospitalizations Current Medical Conditions	Broken bones? If yes, ple	ease explain				
Current Medical Conditions	Surgeries? If yes, please	explain				
Current Medical Conditions						
	•					
Past Medical Conditions	-					
and an extended the state of th	Past Medical Conditions			······································		
Family Health History						
Medication(s)	•					

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

I hereby request and consent to the performance of chiropractic adjustments and other

chiropractic procedures including various modes of physical therapy, and if necessary, diagnostic x-rays on me (or on the patient named below, for whom I am legally responsible:) by the chiropractor and/or anyone working in this office authorized by the chiropractor				
named here _Dr Colby Lovelace and/o me now or in the future at this office. I Lovelace and/or with other office or cli	tic services may be performed by the Chiropractor or other licensed Chiropractor who may treat have had an opportunity to discuss with Dr. Colby inic personnel the nature and purpose of redures. I understand that results are not			
practice of chiropractic carries some ris fractures, disc injuries, strokes (CVA), chiropractor to be able to anticipate and wish to rely on the chiropractor to exerc which the chiropractor feels are in my be known. I have read, or have had read to me, the ask questions about its contents, and by recommended by my chiropractor. I int	n the practice of medicine and all healthcare, the iks to treatment; including, but not limited to: dislocations, and sprains. I do not expect the lexplain all risks and complications. Further, I cise judgment during the course of the procedure pest interests at the time, based upon the facts then above consent. I have also had an opportunity to risigning below, I agree to the treatment tend this consent form to cover the entire course of and for any condition(s) for which I seek treatment			
To be completed by the patient:	To be completed by the patient's representative, if necessary, (eg: if the patient is a minor or is physically or mentally incapacitated)			
Print Patient's Name	Print Name of Patient			
	Print Name of Representative			
Signature of Patient	Signature of Representative			

This form should be maintained in the patient's health record.