Lovelace Chiropractic
& Sports Rehab

PLEASE PRINT

Full Name: _____Date of Birth: _____ Gender: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Phone #: _____ Age: _____ Email Address:_____

Employer: _____ Position:_____

Emergency Contact: _____ Phone #:_____

Are you Medicare Eligible:_____ Do you have a Health Spend Account or Flex Spending: _____

How did you hear about Lovelace Chiropractic and Sports Rehab? If someone referred you, what is their name?

_____

Is there a specific reason for consulting our office, at this time? There is more room on the next page for additional writing.

_____

YOUR HEALTH PROFILE

At Lovelace Chiropractic and Sports Rehab, we focus on your ability to be healthy. Our goals are first to address the issues that brought you to the office, and second, to offer you the opportunity for improved health potential and wellness-services in the future. On a daily basis, we experience physical, chemical and emotional stress that can accumulate and result in a serious loss of health potential. Most times the effects are gradual, not even felt until they become serious. Answering the following questions will give us a profile of the specific stresses you have faced in your lifetime, allowing us to better assess the challenges to your health potential.

YOUR CHILDHOOD YEARS

Research shows that many of the health challenges that occur later in life have their origins during the developmental years, some starting at birth. Please answer the following questions to the best of your ability.

	YES	NO	UNSURE	COMMENTS
Did you have any childhood illness?	☐	☐	☐	_____
Did you have any serious falls as a child?	☐	☐	☐	_____
Did you play youth sports?	☐	☐	☐	_____
Did you take/use any drugs?	☐	☐	☐	_____
Did you have any surgeries?	☐	☐	☐	_____
Have you fallen/jumped from a height over three feet (i.e. crib, bunk bed, trees)?	☐	☐	☐	_____
Were you involved in any car accidents as a child?	☐	☐	☐	_____
Was there any prolonged use of medicine such as antibiotics or an inhaler?	☐	☐	☐	_____
Did you suffer any other traumas (physical or emotional)?	☐	☐	☐	_____
As a child, were you under regular Chiropractic care?	☐	☐	☐	_____

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YOUR ADULT YEARS

	YES	NO	UNSURE	COMMENTS (how often?)
Do you sit at computer for long periods?	☐	☐	☐	_____
Do/did you smoke or drink alcohol?	☐	☐	☐	_____
Have you had any surgeries?	☐	☐	☐	_____
Have you been in a car/bike accident?	☐	☐	☐	_____
Do/did you participate in adult sports?	☐	☐	☐	_____

On a scale of 1 – 10 describe your stress level (1 = none / 10 = extreme): Occupational _____ Personal_____

On a scale of Poor-Good-Excellent describe your: Diet: _____ Exercise: _____ Sleep: _____ General Health: _____

ADDRESSING THE ISSUES THAT BROUGHT YOU TO THE OFFICE

If you have no specific symptoms or complaints, and you are here for Chiropractic Wellness Services please (X) here _____ and skip to the Family Profile section of this form. All others please briefly describe your chief area of complaint, including the effect it has had on your life.

_____

_____

If you are experiencing pain, is it… ☐ Sharp ☐ Dull ☐ Comes and goes ☐ Travels ☐ Constant

Since the problem started, it is… ☐ About the Same ☐ Getting Better ☐ Getting Worse

What makes it worse? _____

Yes, it interferes with… ☐ Work ☐ Sleep ☐ Walking ☐ Sitting ☐ Hobbies ☐ Leisure

Other Doctors seen for this problem (please list):

Chiropractors _____

Medical Doctors _____

Others _____

Please check (X) all symptoms you have ever had, even if they do not seem related to your current problem.

☐ Headache	☐ Pins and Needles in Leg	☐ Fainting	☐ Neck Pain
☐ Fatigue	☐ Loss of Smell	☐ Back Pain	☐ Loss of Balance
☐ Dizziness	☐ Fever	☐ Ringing in Ears	☐ Nervousness
☐ Numbness in Fingers	☐ Numbness in Toes	☐ Loss of Taste	☐ Stomach Upset
☐ Pins and Needles in Arms	☐ Depression	☐ Irritability	☐ Tension
☐ Sleeping Problems	☐ Neck Stiff	☐ Cold Hands	☐ Cold Feet
☐ Diarrhea	☐ Constipation	☐ Buzzing in Ear	☐ Hot Flashes
☐ Cold Sweats	☐ Ulcers	☐ Problem Urinating	☐ Heartburn
☐ Menstrual Irritability	☐ Menstrual Pain	☐ Mood Swing	☐ Eyes Sensitive to Light

List any medications you are now taking: _____

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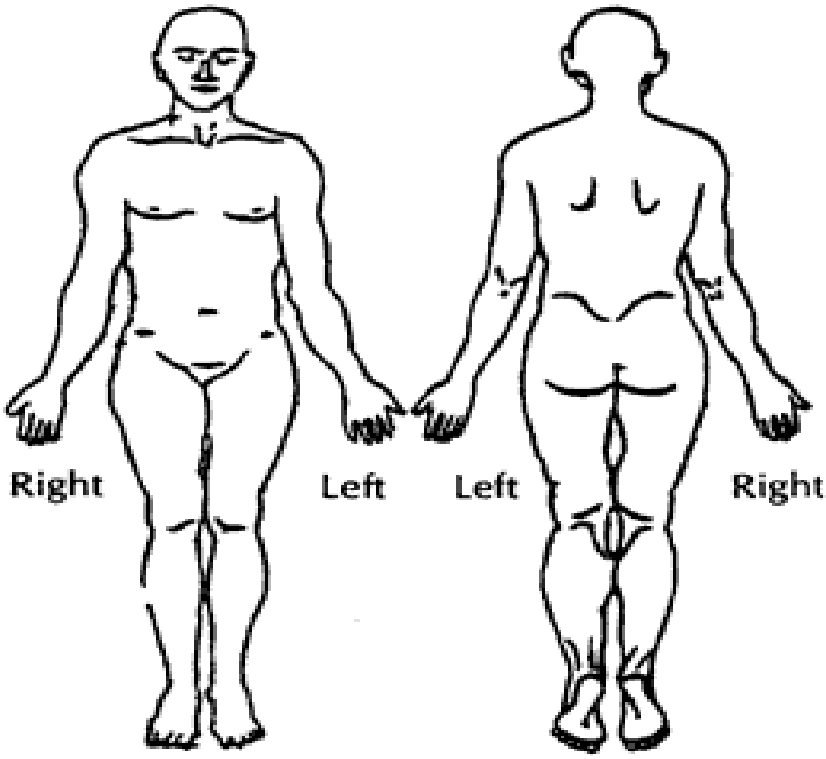
Rate the Severity on a scale of 1 to 10: 1 2 3 4 5 6 7 8 9 10



PAIN DIAGRAM

Please mark the location(s) of your pain using the following symbols:

N = numbness/tingling
^ = sharp/stabbing
B = burning
S = shooting/travelling
A = aching
O = other (describe)
T = tightness

FAMILY HEALTH PROFILE

We are not only interested in your health and well-being, but also about your family and loved ones. Please mention below any health conditions or concerns you may have about your…

Children _____

Spouse/Partner/Significant Other _____

Parents _____

Siblings_____

Others_____

Have you ever:

Belonged to a health club: □ YES □ NO Consumed vitamins or supplements: □ YES□ NO

The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation.

_____ _____

Signature Date

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Informed Consent to Chiropractic Treatment

Informed Consent to Chiropractic Treatment

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including various modes of physiotherapy 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

I further understand that such chiropractic services may ne performed by the chiropractor name here: Dr. Colby Lovelace and/ or other licensed chiropractor who may treat me now or in the future at this office. I have had an opportunity to discuss with Dr. Colby Lovelace and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that as in the practice of medicine and all healthcare, the practice of chiropractic carries some risks to treatment: including but not limited to: fractures, disc injuries, strokes (CVA), dislocations and sprains. I do not expect the chiropractor to be able to anticipate and explain all risks and complications. Further, I wish to rely on the chiropractor to exercise judgement during the course of the procedure which the chiropractor feels are in my best interests at the time, based upon the facts then known.

I have read or have had read to me, the above consent. I have also had an opportunity to ask questions about its contents and by signing below, I agree to the treatment recommended by my chiropractor. I intent this consent form to cover the entire course of treatment for my present condition(s) and for any condition(s) for which I seek treatment at this facility

To be completed by the patients

_____
Print Patient's Name

_____
Signature of 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 Name of Patient

_____
Print Name of Representative

_____
Signature of Representative

This form will be maintained in Patient's health Record

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Financial Agreement

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Patient Name: _____ Date: _____

We would like to take a moment to welcome you to our office and to assure you that you will be receiving the very best care available for your condition. To familiarize you with the financial policy of our office, we would like to explain how your medical bills will be handled.

Payment Arrangements

It is our policy to maintain your account on a current basis. Charges for treatment are due at the time service is provided. If your account is NOT paid on time, it may be subject to a finance charge.

_____Private Pay Patients: Payment is due at the time of treatment.

_____Auto/Personal Injury Patients: Regardless of fault, you are ultimately responsible for all treatment you receive. Personal injury cases require one of the following confirmed sources of payment:

A. A signed Doctor's lien or Letter of Protection from your Attorney
B. Other arrangements:_____

I have read and agree to the above statements:

Patient's Name (Print): _____

Patient's Signature:_____ *Date:*_____