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

Name _____ Occupation _____

Have you had chiropractic care before? ☐Yes ☐No When/Where? _____

Reason for today's visit _____ When did this begin? _____

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) 1 2 3 4 5 6 7 8 9 10

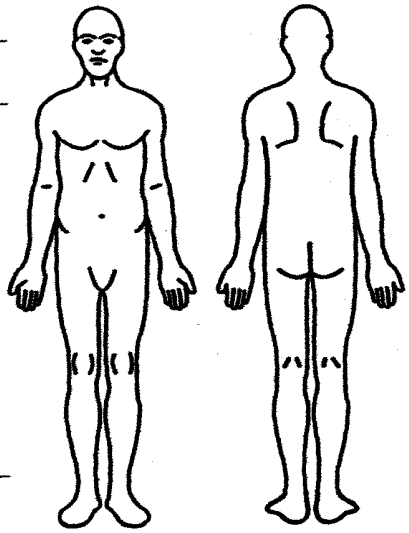
Type of Pain? ☐ Sharp ☐ Dull ☐ Throbbing

☐ 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
☐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 _____

Past Medical Conditions _____

Family Health History _____

Medication(s) _____

Other _____

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

I further understand that such chiropractic services may be performed by the Chiropractor named 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 judgment 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 intend 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 patient:

_____
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 should be maintained in the patient's health record.