Lovett Family Chiropractic & Wellness Center
Dr. Patrick Lovett D.C., C.C.C.N.
12201 E Arapahoe Rd # B10
Centennial, CO 80112
Ph: 720-747-1500
www.lovettfamilychiro.com

Get Well. Stay Well.

INTEGRITY Doctors
verified chiropractor

What to expect from your first two visits:

- An in depth consultation, neurological and orthopedic examination, as well as any necessary x-rays (if needed) will be performed on the first day. There is a fee for these services.

- At the second appointment, Dr. Lovett will explain the full report of his findings from your examination and what it will take to correct your condition. If you are receive treatment on the second day you will be responsible for payment. Please let us know if you have any questions.

Your appointment is _____

Map to our office:

We are located on the Northeast corner of Arapahoe Rd. & Peoria St.

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#:_____ Birth Date:_____ Age:_____

Occupation: _____ Employer: _____

Home #:_____ Cell #:_____ Ok to contact you via text: YES NO

E-Mail: _____ Ok to E-mail LFC Newsletter to you: YES NO

E-mail is the primary way that we communicate with our patients regarding upcoming appointments.

*Your information (including e-mail address & phone number will NEVER be shared with anyone)

Spouse: _____ Phone#:_____

How many children? _____ Names and Ages of Children:_____

Emergency Contact: _____ Phone #: _____ Relationship: _____

Who referred you to our office? _____

Family Medical Doctor: _____ Phone: _____

To ensure continuity of care we will send a letter to your medical doctor. Please sign below to allow us to do so:

Signature: _____

PAST MEDICAL HISTORY

Have you ever been diagnosed as having or have suffered from? (Place a check by those that apply to you)

__Broken or Fractured Bones	__Osteoarthritis	__Eating Disorder	__Tumors
__Circulatory Problems	__Epilepsy	__Alcoholism	__Skin Disorders
__Rheumatoid Arthritis	__Pacemaker/IED	__Drug Addiction	__Diabetes
__Seizures/Convulsions	__Strokes	__HIV Positive	__Vascular problems
__A Congenital Disease	__Cancer	__Gall Bladder	__Ulcers
__Excessive Bleeding	__Ruptures	__Depression	__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 in your lifetime? 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? _____

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:

_____

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, **C**hildren):

_____Neck Pain _____Back Pain _____Headaches _____Neuropathy

_____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/Guardian Signature: _____ 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. Describe the pain: _____Sharp _____Dull _____Numbness _____Tingling _____Aching
   _____Burning _____Stabbing _____Other _____
7. 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? _____
8. What makes the problem worse? ___Standing ___Sitting ___Lying ___Bending
   ___Lifting ___ Twisting ___Other _____
9. List any major accidents you have had other than those that might be mentioned above:
   _____
10. WOMEN ONLY: Are you pregnant or is there any possibility you may be pregnant?
    YES NO UNCERTAIN
11. Other Concerns _____
12. How does this problem effect your day to day life? (ie: difficulty sleeping, working, walking, driving, doing things at home etc…)_____
_____
13. What are you not able to do because of your chief complaint, that you would like to be able to do?
_____

Rate your pain fron 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 _____

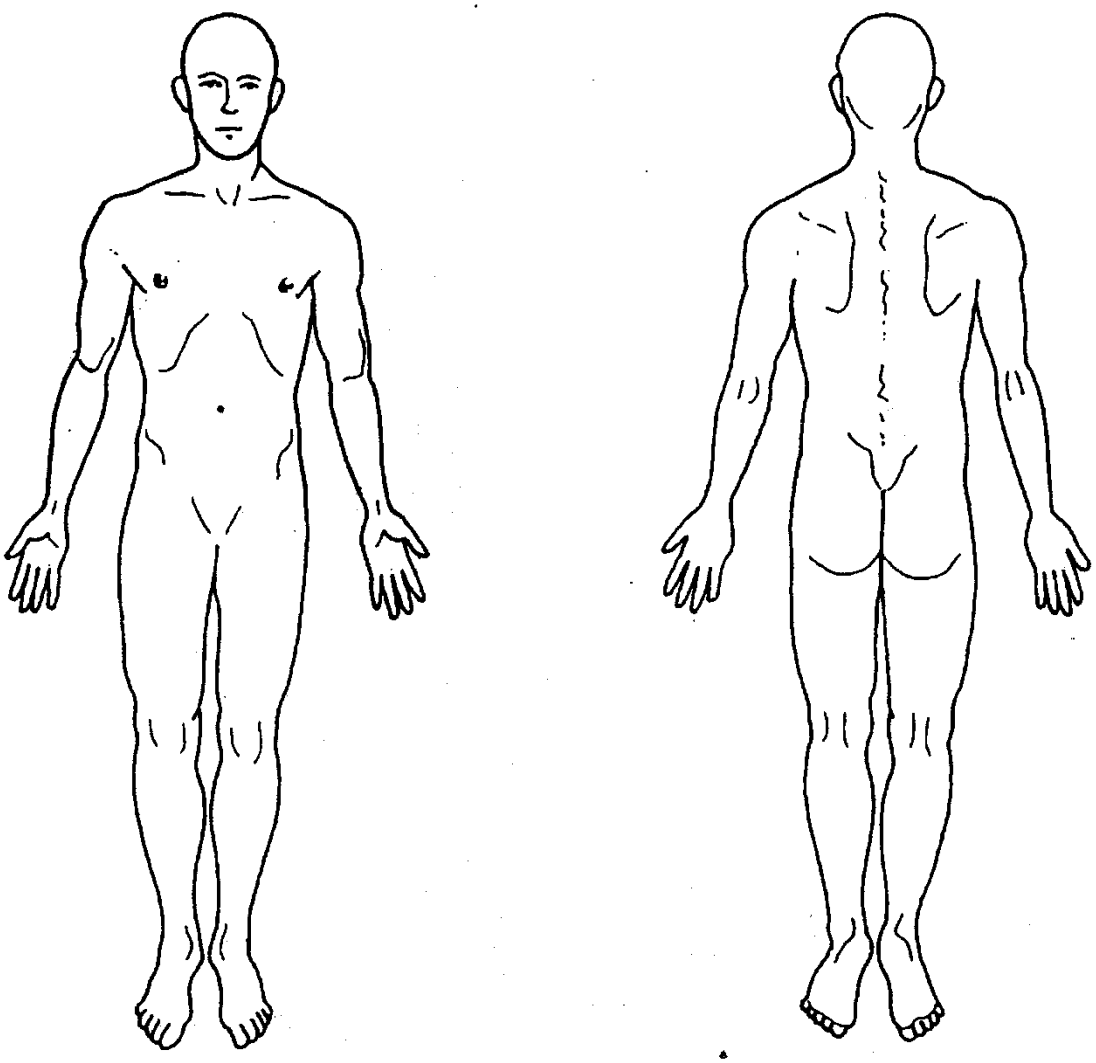
Doctor's Signature _____ Date _____

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 start to where it stops. Please extend the arrow as far as the pain travels. Use the appropriate symbol(s) listed below.

Ache = A	Numbness = N	Pins & Needles = P
Burning = B	Stabbing = S	Throbbing = T



Informed Consent For Chiropractic Care and Therapies

Chiropractic care, like ALL forms of health care, while offering considerable benefit may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care and therapies include stiffness, soreness, discomfort, skin irritation, sprain/strain injuries, irritation of a disc condition, and very rarely, fractures.

Prior to receiving chiropractic care this Chiropractic office performs a thorough health history and physical examination on every potential patient. These procedures are performed to assess your specific condition, your overall health and, in particular, your spinal health. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies are needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan prior to beginning care.

I understand that chiropractic adjustments involve the doctor placing his or her hands on me and delivering a very specific, quick thrust or impulse to the involved area(s). Alternatively, the doctor may use an instrument in place of his or her hands. I understand and accept that there are risks and benefits associated with chiropractic care and give my consent to the examinations that the doctor deems necessary, and to the chiropractic care including spinal adjustments and other therapies, as reported following my assessment.

_____	_____	_____
Printed Name	Signature of Patient/Guardian	Date

Informed Consent to X-Rays (Pregnancy Release)

In order for Lovett Family Chiropractic to correctly evaluate, diagnose and treat my condition, x-rays may be needed. X-Rays expose the patient to small doses of radiation. Repeated exposure to radiation has been correlated to increase cancer risk. I grant LFC permission to perform x-rays, if needed, and assume all risks and responsibilities from an x-ray procedure.

The radiation in x-rays may be harmful to an unborn child/developing fetus. I understand that there are risks involved in exposing an unborn child to radiation and assume all responsibility for receiving an x-ray procedure. By my signature below, I certify that I am not pregnant at the time of this x-ray procedure.

_____	_____	_____
Printed Name	Signature of Patient/Guardian	Date

Pacemaker/Defibrilator Release

I hereby certify that I do not have a Pacemaker of Defibrilator of any kind in or on my body. I understand that if I do have one of these devices in or on my body, I will let the doctor know and my treatment may be slightly altered as a result. Pacemakers and Defibrilators are NOT contraindicated with chiropractic care but they ARE contraindicated with cold laser therapy.

_____	_____	_____
Printed Name	Signature of Patient/Guardian	Date

Patient Acknowledgement and Receipt of Notice of Privacy Practices Pursuant to HIPAA and Consent for Use of Health Information

Name_____ Date_____
Print Patient's Name

The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant To HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request.

The undersign does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State law and Federal Law.

Dated this _____ day of _____, 20___

By_____
Patient's Signature

If patient is a minor or under a guardianship order as defined by State law:

By_____
Signature of Parent/Guardian (circle one)

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Six Steps to Identifying and Correcting the Cause of Your Problem

1. ***Fact Finding-*** During your initial visit you will take part in a consultation, examination and x-rays if necessary, to figure out exactly what is causing your symptom. (Example: Back pain is not your problem, it is a symptom. We need to figure out the problem that is causing your symptom.)
2. ***Dr. Analyzes the Results-*** In between your initial and second visit, the doctor will take time to review and analyze all of the information that was gathered during your initial visit to come up with the most accurate diagnosis for your condition and the best course of action to address your condition.
3. ***Report of Findings-*** This will take place during your second visit to our office. The doctor will review with you the findings from your consultation, exam and x-rays. At this time the doctor will let you know if your condition is appropriate for chiropractic care or if you need to be referred to another type of care provider. If the doctor determines that your condition is appropriate for chiropractic care, at this time he will recommend a treatment plan necessary to correct your condition.
4. ***Cost of Care Estimate-*** After your Report of Findings, our front desk Chiropractic Assistant will review your personalized cost of care estimate based on your treatment plan. It will include any insurance coverage co-pays and deductibles that the Assistant was able to verify with your insurance company.
5. ***Treatment-*** Your treatment plan will include the essential procedures and modalities to address your specific condition. Nothing less and nothing more. See the next page for more information on the procedures/modalities available at our office.
6. ***How to Stay Young the First 100 Years class-*** This is a riveting class about the beneficial aspects of chiropractic care. All New Patients attend the class once within the first two weeks of beginning care. It is offered in the office every Tuesday at 12:45 and every Wednesday at 6:15. We can couple one of your appointments to match up with the class so that you do not have to make a separate trip. We encourage you to bring family and friends to this informative presentation. The more that they understand what you are going through, the better they will be able to support your recovery.

Explanation of Chiropractic Adjustments and Modalities

Chiropractic Adjustments- Adjustments can be performed by hand or by instrument. They allow the joints of the body to move properly. When the joints move properly it takes pressure off of the nerves which allows the nerves to function properly. These nerves control every cell, tissue and organ in our body. Thus by helping the nerves to function properly, chiropractic adjustments improve the health and function of our entire body, as well as decreasing pain. Chiropractic adjustments are safe and effective for all ages of adults and children.

Cold Laser Therapy- Cold Laser Therapy works on a cellular level to decrease pain, decrease inflammation and increase healing. It is called "cold" because it is such a low level of energy that it does not create heat. It helps the mitochondria of the cells to increase the production of ATP (cellular energy) which helps cells to heal faster.

Rehabilitation- Rehab involves active exercises that work to re-train the brain and body to hold your body in proper alignment after your adjustments. Rehab works to strengthen and stabilize your spine and support your adjustments. Rehab should be performed every day at home, just like brushing your teeth, in order to get the best results.

Interferential Therapy- Interferential current therapy is a treatment to aid the relief of pain and the promotion of soft-tissue healing. Tiny electrical impulses are sent into the tissues in the area of the pain. The low-frequency stimulation induces the body to secrete endorphins, which are the body's natural pain-killers. Most patients find interferential therapy to be very beneficial and describe the treatment as being relaxing and having a 'pins and needles' sensation.

Neck Orthotic- The neck orthotic is recommended for patients who have no curve or a reverse curve to their neck. The Neck Orthotic helps to re-establish the proper curve in your neck. Proper curve in the neck is very important for your overall neurological health. You lay on the neck orthotic for 2-15 minutes per day at home. (specific directions are provided)

Kinesio-Tape- Kinesio-tape works to support muscles and joints of the body. Kinesio-tape differs from traditional athletic tape because it is highly flexible, hypo-allergenic, water resistant and can stay on the body for up to seven days. Kinesio-tape can be used for neck pain, back pain, pain in the arms and legs, sprained or strained muscles, swelling and bruising.

ALINE Foot Orthotics- Orthotics support the natural arches of the foot and help to correct pronation and supination of the foot. (rolling in or out on the foot) ALINE Orthotics are unique because we can very accurately measure the degree of pronation or supination and quickly develop a semi-custom orthotic that will correct the biomechanical dysfunction in the foot. Orthotics are great for patients with foot, ankle, knee, hip and even low back problems.

Ionic Foot Bath Detoxification- The ionic foot bath pulls toxins out through the feet by polarizing the water, sort of like a magnet. Toxins often get caught inside of our body, particularly in fatty tissue, and get stuck there. The foot bath polarizes the extracellular matrix of our body to release the toxins so they can be excreted for days afterward. Patients often say they feel more energy, think clearer and feel better after a foot bath.